State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: DC-SG-UHIC-2020-01
State: District of Columbia

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003G Small Group Only - Other

Filing Type: Rate

Date Submitted: 05/24/2019

SERFF Tr Num: UHLC-131909980

SERFF Status: Assigned

State Tr Num: State Status: Co Tr Num:

Implementation 01/01/2020

Date Requested:

Author(s): Bonnie Barboza, Esther Drew, Michelle Lorenzo, Ryan Morgan, Alysia Krzanowski, Juliana

Mello

Reviewer(s): Damon Siler (primary), John Morgan, Efren Tanhehco, Dave Dillon

Disposition Date:
Disposition Status:
Implementation Date:

State Filing Description:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

General Information

Project Name: Status of Filing in Domicile:
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small
Group Market Type: Employer Overall Rate Impact: 11.2%

Filing Status Changed: 05/28/2019

State Status Changed: Deemer Date:

Created By: Ryan Morgan Submitted By: Ryan Morgan

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions:

Filing Description:

2020 DC SG UHIC Rate Filing - Average rate increase 11.2%

Company and Contact

Filing Contact Information

Ryan Morgan, ryan_morgan2@uhc.com 10701 W Research Dr 414-443-4287 [Phone]

Wauwatosa, WI 53226

Filing Company Information

UnitedHealthcare Insurance CoCode: 79413 State of Domicile: Connecticut Company Group Code: 707 Company Type: Life and

185 Asylum Street Group Name: Health

Hartford, CT 06103 FEIN Number: 36-2739571 State ID Number: 79413

(860) 702-5000 ext. [Phone]

Filing Fees

Fee Required? No Retaliatory? No

Fee Explanation:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Correspondence Summary

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Rate	Rate Filing Exhibits	Juliana Mello	05/29/2019	05/29/2019
Supporting Document	Risk Adjustment RATEE Data	Ryan Morgan	05/27/2019	05/27/2019

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Amendment Letter

Submitted Date: 05/29/2019

Comments:

We are adding a PDF version of our rate filing exhibits. Please let us know if you have any questions.

Best,

Juliana

Changed Items:

No Form Schedule Items Changed.

Rate/Rule Schedule	Item Changes					
Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Rate Filing Exhibits		Revised	Previous State Filing Number: UHLC-131461282 Percent Rate Change Request: 11.2	DC-SG-UHIC-Exhibits 2020-1-v1.xlsx, DC- SG-UHIC-Exhibits 2020-1-v1.pdf,	05/29/2019 By:
Previous Version						
1	Rate Filing Exhibits		Revised	Previous State Filing Number: UHLC-131461282 Percent Rate Change Request: 11.2	DC-SG-UHIC-Exhibits 2020-1-v1.xlsx,	05/24/2019 By: Ryan Morgan

No Supporting Documents Changed.

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Amendment Letter

Submitted Date: 05/27/2019

Comments:

It came to my attention the RATEE data submitted with the filing was from 2017. This amendment corrects this and includes 2018 RATEE data. Please let me know if you have any questions.

Best,

Ryan

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document So	chedule Item Changes
Satisfied - Item:	Risk Adjustment RATEE Data
Comments:	
Attachment(s):	DC Confidentiality Cover Letter EDGE Data 5.24.19.pdf 41842.RATEE.D20190503T004836.P.xml
Previous Version	
Satisfied - Item:	Risk Adjustment RATEE Data
Comments:	
Attachment(s):	41842.RATEE.D20180501T060434.P.xml DC Confidentiality Cover Letter EDGE Data 5.24.19.pdf

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: Review & Approval

Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 9.800%
Effective Date of Last Rate Revision: 01/01/2019

Filing Method of Last Filing: Review & Approval SERFF Tracking Number of Last Filing: UHLC-131461282

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Premium for	Maximum % Change (where req'd)	Minimum % Change : (where req'd):
UnitedHealthcare Insurance Company	Increase	11.200%	11.200%	\$6,840,775	1,674	\$60,860,988	15.600%	5.900%

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Rate Review Detail

COMPANY:

Company Name: UnitedHealthcare Insurance Company

HHS Issuer Id: 25978

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered
			Lives
EPO & POS			8509

Trend Factors: The current annual trend factor is 8.1% The proposed 2020 annual trend factor is 8.3%

FORMS:

New Policy Forms: POL.SHOP.I.2018.SG.DC, COC.SHOP.I.2018.SG.DC, SBN.CHP.I.2018.SG.DC.PL1,

SBN.CHP.I.2018.SG.DC.PL3, SBN.CHP.I.2018.SG.DC.PL4, SBN.CHP.I.2018.SG.DC.PL6, SBN.CHP.I.2018.SG.DC.PL14, SBN.CHP.I.2018.SG.DC.GO7, SBN.CHP.I.2018.SG.DC.GO8, SBN.CHP.I.2018.SG.DC.GO10, SBN.CHP.I.2018.SG.DC.GO11, SBN.CHP.I.2018.SG.DC.GO13, SBN.CHP.I.2018.SG.DC.GO21, SBN.CHP.I.2018.SG.DC.GO22, SBN.CHP.I.2018.SG.DC.SL8, SBN.CHP.I.2018.SG.DC.SL11, SBN.CHP.I.2018.SG.DC.SL15, SBN.CHP.I.2018.SG.DC.SL11, SBN.CHP.I.2018.SG.DC.SL17, SBN.CHP.I.2018.SG.DC.SL17, SBN.CHC.I.2018.SG.DC.PL4, SBN.CHC.I.2018.SG.DC.PL4, SBN.CHC.I.2018.SG.DC.GO11, SBN.CHC.I.2018.SG.DC.GO11, SBN.CHC.I.2018.SG.DC.GO14, SBN.CHC.I.2018.SG.DC.GO14, SBN.CHC.I.2018.SG.DC.GO22, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL15,

SBN.CHC.I.2018.SG.DC.BR4, RID.PDS.NET.I.2018.SG.DC, RID.PDS.NET-

OON.I.2018.SG.DC RID.PVCS.NET.I.2018.SG.DC, RID.PVCS.NET-

SBN.CHC.I.2018.SG.DC.SL16, SBN.CHC.I.2018.SG.DC.SL17,

OON.I.2018.SG.DC, RID.RX.NET.I.2018.SG.DC,

Affected Forms:

Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 127,463
Benefit Change: Increase

Percent Change Requested: Min: 5.9 Max: 15.6 Avg: 11.2

PRIOR RATE:

Total Earned Premium: 60,860,988.00 Total Incurred Claims: 49,314,197.00

Annual \$: Min: 174.63 Max: 1,195.62 Avg: 477.48

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

REQUESTED RATE:

Projected Earned Premium: 67,701,763.00 Projected Incurred Claims: 53,803,004.00

Annual \$: Min: 195.65 Max: 1,382.16 Avg: 531.15

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Filing Exhibits		Revised	Previous State Filing Number: UHLC-131461282 Percent Rate Change Request: 11.2	DC-SG-UHIC-Exhibits 2020-1-v1.xlsx, DC- SG-UHIC-Exhibits 2020-1-v1.pdf,

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Attachment DC-SG-UHIC-Exhibits 2020-1-v1.xlsx is not a PDF document and cannot be reproduced here.

Rate Factors Exhibit 1

(1) Base Rate: \$766.11

(2) Benefit Plan Ratios

	CH/I	NS (EPO) P	ans		
	Medical	Rx			
	Plan	Plan	Metal	Actuarial	Plan
Product	Name	Name	Level	Value	Ratio
EPO	BQ-AK	813	Gold 22	81.1%	0.6546
EPO	BQ-AW	819	Gold 23	79.9%	0.5543
EPO	BQ-AZ	819	Silver 19	72.0%	0.4461
EPO	BQ-A5	816	Gold 13	81.5%	0.5694
EPO	BQ-A7	818	Gold 26	77.6%	0.5127
EPO	BQ-A9	816	Gold 8	81.8%	0.5522
EPO	BQ-BB	814	Platinum 1	89.6%	0.7442
EPO	BQ-BD	820	Platinum 4	88.7%	0.7884
EPO	BQ-BI	818	Silver 8	71.8%	0.4463
EPO HSA	BH-E3	575	Bronze 4	62.6%	0.3905
EPO HSA	BH-EZ	816	Gold 1	81.3%	0.6039
EPO HSA	BQ-BF	816	Silver 11	71.6%	0.5029

		CH+/IN	IS (POS) Plans	5	
	Medical	Rx			
	Plan	Plan	Metal	Actuarial	Plan
Product	Name	Name	Level	Value	Ratio
POS	BQ-AL	A85	Gold 29	79.8%	0.5556
POS	BQ-AM	813	Gold 22	81.1%	0.6614
POS	BQ-AN	818	Gold 28	81.9%	0.5683
POS	BQ-AQ	845	Plat 14	91.2%	0.8272
POS	BQ-AR	A85	Plat 15	86.3%	0.6681
POS	BQ-AX	819	Gold 23	79.9%	0.5642
POS	BQ-AY	819	Gold 31	76.0%	0.4921
POS	BQ-A2	819	Silver 19	72.0%	0.4540
POS	BQ-A3	814	Platinum 1	89.6%	0.7558
POS	BQ-A6	816	Gold 10	81.2%	0.5627
POS	BQ-A8	816	Gold 8	81.8%	0.5627
POS	BQ-BA	816	Gold 13	81.5%	0.5793
POS	BQ-BC	818	Gold 26	77.6%	0.5221
POS	BQ-BE	818	Silver 8	71.8%	0.4549
POS	BQ-BJ	820	Platinum 4	88.7%	0.8006
POS HSA	BH-E6	816	Gold 1	81.3%	0.6162
POS HSA	BQ-AO	816	Gold 7	81.4%	0.6537
POS HSA	BQ-BG	816	Silver 11	71.6%	0.5132

(3) Effective Date Adjustment Factors (EDA's)

Effective Quarter	<u>Trend</u>
1st Quarter, 2020	1.000
2nd Quarter, 2020	1.020
3rd Quarter, 2020	1.041
4th Quarter, 2020	1.062

(4) Age Fa	ctors				
<u>Age</u>	<u>Factor</u>	<u>Age</u>	<u>Factor</u>	<u>Age</u>	Factor
0-20	0.654	35	0.876	50	1.431
21	0.727	36	0.896	51	1.487
22	0.727	37	0.916	52	1.545
23	0.727	38	0.927	53	1.605
24	0.727	39	0.938	54	1.668
25	0.727	40	0.975	55	1.733
26	0.727	41	1.013	56	1.801
27	0.727	42	1.053	57	1.871
28	0.744	43	1.094	58	1.944
29	0.760	44	1.137	59	2.020
30	0.779	45	1.181	60	2.099
31	0.799	46	1.227	61	2.181
32	0.817	47	1.275	62	2.181
33	0.836	48	1.325	63	2.181
34	0.856	49	1.377	64 & older	2.181

DC Small Group - 2020 Portfolio - UnitedHealthcare Insurance Company

								Ir	-Netwo	rk			Out	-of-Net	work					Copayments				Medical				Rx		
	F	Plan Name		Metal	Act'l	Plan	Dedu	uctible	111111111111111111111111111111111111111		laximum	Dedu	ıctible	0. 1100		1aximum				Copayments	OF	Surgery		Deduct.	Deduct.		1		ier 2	Tier 3
Produ	ict M	ledical R	x SCID	Level	Value	Ratio	Indiv.	Family	Coins	Indiv.	Family	Indiv.	Family	Coins	Indiv.	Family	PCP	SCP	UC	ER	Free-St.	Hospital	IP	Type	Type	Deduct.	Tier 1	Tier 2 S	pec. Tier	3 Spec. Tier 4
EPO	В	3Q-AK 81	.3 41842DC0040057-01	Gold 22	81.1%	0.6546	\$0	\$0	100%	\$7,900	\$15,800						\$30	\$60	\$30	\$500	\$600	\$600	\$1000 x 3	Emb	Sep		\$10	\$50	\$100	\$150
EPO	B(Q-AW 81	.9 41842DC0040062-01	Gold 23	79.9%	0.5543	\$1,000	\$2,000	80%	\$7,900	\$15,800							\$40	\$25					Emb	Sep	\$250	\$5	\$40 \$3	120 \$75	\$150
EPO	В	3Q-AZ 81	.9 41842DC0040065-01	Silver 19	72.0%	0.4461	\$5,000	\$10,000	70%	\$8,150	\$16,300							\$50	\$25					Emb	Sep	\$250	\$5	\$40 \$3	120 \$75	\$150
EPO	В	3Q-A5 81	.6 41842DC0040045-01	Gold 13	81.5%	0.5694	\$1,750	\$4,500	100%	\$6,500	\$13,000						\$25	\$50	\$25	\$250 POD		\$250 POD		Emb	Sep		\$10	\$40 \$:	120 \$75	\$150
EPO	В	3Q-A7 81	.8 41842DC0040064-01	Gold 26	77.6%	0.5127	\$2,000	\$4,000	100%	\$6,000	\$12,000						\$30	\$60 CAD	\$30	\$500 CAD	\$150 POD	\$300 POD	\$500 CAD Admit	Emb	Sep	\$250	\$10	\$40 \$3	120 \$75	\$150
EPO	В	BQ-A9 81	.6 41842DC0040091-01	Gold 8	81.8%	0.5522	\$1,250	\$2,500	80%	\$4,250	\$8,500						\$30	\$60	\$30			\$250 POD		Emb	Sep		\$10	\$40 \$:		\$150
EPO	В	Q-BB 81	.4 41842DC0040059-01	Platinum 1	89.6%	0.7442	\$250	\$500	100%	\$2,500	\$5,000						\$15	\$30	\$15	\$250		\$250 POD		Emb	Sep		\$10	\$40 \$:	100 \$75	\$150
EPO	B	Q-BD 82	0 41842DC0040060-01	Platinum 4	88.7%	0.7884	\$0	\$0	100%	\$5,000	\$10,000						\$15	\$30	\$15	\$250		\$150		Emb	Sep		\$15	\$25 \$:	100 \$50	\$150
EPO	В	BQ-BI 81	.8 41842DC0040101-01	Silver 8	71.8%	0.4463	\$2,750	\$5,500	70%	\$8,150	\$16,300						\$50	\$100	\$50					Emb	Sep	\$250	\$10	\$40 \$:	120 \$75	\$150
EPO H	SA B	3H-E3 57	5 41842DC0040008-01	Bronze 4	62.6%	0.3905	\$6,700	\$13,400	100%	\$6,700	\$13,400													Emb	Comb		\$0	\$0	\$0	
EPO H	SA B	3H-EZ 81	.6 41842DC0040061-01	Gold 1	81.3%	0.6039	\$1,400	\$2,800	90%	\$3,500	\$7,000													Non-Emb	Comb		\$10	\$40 \$:	120 \$75	\$150
EPO H	SA B	3Q-BF 81	.6 41842DC0040046-01	Silver 11	71.6%	0.5029	\$2,750	\$5,500	100%	\$6,700	\$13,400						\$25 CAD	\$50 CAD	\$25 CAD	\$250 CAD		\$250 POD	\$500 CAD Admit	Non-Emb Ded (Emb OOP)	Comb		\$10	\$40 \$3	120 \$75	\$150
POS	В	Q-AL A	85 41842DC0010085-01	Gold 29	79.8%	0.5556	\$2,020	\$4,040	80%	\$7,900	\$15,800	\$10,000	\$20,000	60%	\$15,000	\$30,000	\$20	\$20	\$20					Emb	Sep		20%	20% 2	20% 20%	6 20%
POS	B	Q-AM 81	.3 41842DC0010078-01	Gold 22	81.1%	0.6614	\$0	\$0	100%	\$7,900	\$15,800	\$15,000	\$30,000	50%	\$30,000	\$60,000	\$30	\$60	\$30	\$500	\$600	\$600	\$1000 x 3	Emb	Sep		\$10	\$50	\$100	\$150
POS	В	Q-AN 81	.8 41842DC0010086-01	Gold 28	81.9%	0.5683	\$0	\$0	70%	\$7,900	\$15,800	\$15,000	\$30,000	50%	\$30,000	\$60,000								Emb	Sep	\$250	\$10	\$40 \$:	120 \$75	\$150
POS	B	Q-AQ 84	5 41842DC0010074-01	Plat 14	91.2%	0.8272	\$0	\$0	100%	\$4,000	\$8,000	\$500	\$1,000	80%	\$4,000	\$8,000	\$10	\$20	\$10	\$200	\$150	\$150		Emb	Sep		\$10	\$40	\$75	
POS	В	Q-AR A	35 41842DC0010087-01	Plat 15	86.3%	0.6681	\$0	\$0	80%	\$6,500	\$13,000	\$5,000	\$10,000	60%	\$10,000	\$20,000	\$20	\$20	\$20					Emb	Sep		20%	20% 2	20% 20%	6 20%
POS	В	Q-AX 81	9 41842DC0010082-01	Gold 23	79.9%	0.5642	\$1,000	\$2,000	80%	\$7,900	\$15,800	\$2,000	\$4,000	60%	\$15,000	\$30,000		\$40	\$25					Emb	Sep	\$250	\$5	\$40 \$3	120 \$75	\$150
POS	В	3Q-AY 81	.9 41842DC0010088-01	Gold 31	76.0%	0.4921	\$2,750	\$5,500	80%	\$7,900	\$15,800	\$6,000	\$12,000	60%	\$15,000	\$30,000		\$50	\$25					Emb-Custom	Sep	\$250	\$5	\$40 \$3	120 \$75	\$150
POS	В	3Q-A2 81	.9 41842DC0010089-01	Silver 19	72.0%	0.4540	\$5,000	\$10,000	70%	\$8,150	\$16,300	\$10,000	\$20,000	60%	\$15,000	\$30,000		\$50	\$25					Emb	Sep	\$250	\$5	\$40 \$:	120 \$75	\$150
POS	В	3Q-A3 81	4 41842DC0010066-01	Platinum 1	89.6%	0.7558	\$250	\$500	100%	\$2,500	\$5,000	\$2,000	\$4,000	70%	\$6,000	\$12,000	\$15	\$30	\$15	\$250		\$250 POD		Emb	Sep		\$10	\$40 \$3	100 \$75	\$150
POS	В	3Q-A6 81	.6 41842DC0010032-01	Gold 10	81.2%	0.5627	\$750	\$1,500	80%	\$7,500	\$15,000	\$2,000	\$4,000	60%	\$15,000	\$30,000	\$20	\$40	\$20	\$250 POD		\$250 POD		Emb	Sep		\$10	\$40 \$:	120 \$75	\$150
POS	В	3Q-A8 81	.6 41842DC0010054-01	Gold 8	81.8%	0.5627	\$1,250	\$2,500	80%	\$4,250	\$8,500	\$3,000	\$6,000	70%	\$8,000	\$16,000	\$30	\$60	\$30			\$250 POD		Emb	Sep		\$10	\$40 \$3	120 \$75	\$150
POS	В	Q-BA 81	.6 41842DC0010042-01	Gold 13	81.5%	0.5793	\$1,750	\$4,500	100%	\$6,500	\$13,000	\$4,000	\$8,000	70%	\$10,000	\$20,000	\$25	\$50	\$25	\$250 POD		\$250 POD		Emb	Sep		\$10	\$40 \$3	120 \$75	\$150
POS	В	3Q-BC 81	.8 41842DC0010084-01	Gold 26	77.6%	0.5221	\$2,000	\$4,000	100%	\$6,000	\$12,000	\$5,000	\$10,000	80%	\$15,000	\$30,000	\$30	\$60 CAD	\$30	\$500 CAD	\$150 POD	\$300 POD	\$500 CAD Admit	Emb	Sep	\$250	\$10	\$40 \$3	120 \$75	\$150
POS	В	3Q-BE 81	8 41842DC0010080-01	Silver 8	71.8%	0.4549	\$2,750	\$5,500	70%	\$8,150	\$16,300	\$5,000	\$10,000	50%	\$15,000	\$20,000	\$50	\$100	\$50					Emb	Sep	\$250	\$10	\$40 \$	120 \$75	\$150
POS	В	3Q-BJ 82	0 41842DC0010068-01	Platinum 4	88.7%	0.8006	\$0	\$0	100%	\$5,000	\$10,000	\$1,000	\$2,000	70%	\$6,000	\$12,000	\$15	\$30	\$15	\$250		\$150		Emb	Sep		\$15	\$25 \$	100 \$50	\$150
POS H	SA B	3H-E6 81	.6 41842DC0010081-01	Gold 1	81.3%	0.6162	\$1,400	\$2,800	90%	\$3,500	\$7,000	\$2,000	\$4,000	70%	\$6,000	\$12,000	1							Non-Emb	Comb		\$10	\$40 \$:	120 \$75	\$150
POS H	SA B	Q-AO 81	.6 41842DC0010006-01	Gold 7	81.4%	0.6537	\$1,750	\$3,500	100%	\$3,000	\$6,000	\$3,000	\$6,000	70%	\$6,000	\$12,000	1			\$250 CAD				Non-Emb Ded (Emb OOP)	Comb		\$10	\$40 \$	120 \$75	\$150
POS H	SA B	O-BG 81	.6 41842DC0010043-01	Silver 11	71.6%	0.5132	\$2,750	\$5,500	100%	\$6,700	\$13,400	\$5,000	\$10,000	80%	\$10,000	\$20,000	\$25 CAD	\$50 CAD	\$25 CAD	\$250 CAD		\$250 POD	\$500 CAD Admit	Non-Emb Ded (Emb OOP)	Comb		\$10	\$40 \$:	120 \$75	\$150

Year Over Year Rate Change

Rate Changes - Base Rates, Benefit Plan Ratios and Effective Date Adjustment (EDA) Factors (from Exhibit 1)

_						nt - 4th Qu	arter 201	9 Rate	Proposed	- 1st Quarte	r 2020 Rate	% Rate	Min: 5.9%		Max: 15.6%	
					Base	Plan	EDA	4Q2019	Base	Plan	1Q2020	Change	1Q19	2Q19	3Q19	4Q19
	Plan N				Rate	Ratio	Factor	Rate =	Rate	Ratio	Rate =	4Q19	to	to	to	to
Product	2019	2020	Rx		(a)	(b)	(c)	(a x b x c)	(d)	(e)	(d x e)	to 1Q20	1Q20	2Q20	3Q20	4Q20
EPO	BH-E7	BQ-AK	813		\$652.85	0.6814	1.081	\$480.89	\$766.11	0.6546	\$501.50	4.3%	12.7%	12.1%	11.4%	10.7%
EPO	BH-FE	BQ-AW	819		\$652.85	0.5877	1.081	\$414.76	\$766.11	0.5543	\$424.65	2.4%	10.7%	10.0%	9.4%	8.7%
EPO	BH-FR	BQ-A5	816		\$652.85	0.6121	1.081	\$431.98	\$766.11	0.5694	\$436.22	1.0%	9.2%	8.5%	7.9%	7.2%
EPO	BH-FV	BQ-A7	818		\$652.85	0.5480	1.081	\$386.74	\$766.11	0.5127	\$392.78	1.6%	9.8%	9.2%	8.5%	7.8%
EPO	BH-FN	BQ-A9	816		\$652.85	0.5835	1.081	\$411.79	\$766.11	0.5522	\$423.05	2.7%	11.1%	10.4%	9.7%	9.1%
EPO	BH-F2	BQ-BB	814		\$652.85	0.7628	1.081	\$538.33	\$766.11	0.7442	\$570.14	5.9%	14.5%	13.8%	13.1%	12.4%
EPO	BH-F5	BQ-BD	820		\$652.85	0.8021	1.081	\$566.07	\$766.11	0.7884	\$604.00	6.7%	15.3%	14.7%	14.0%	13.3%
EPO	BH-FY	BQ-BI	818		\$652.85	0.4764	1.081	\$336.21	\$766.11	0.4463	\$341.91	1.7%	9.9%	9.3%	8.6%	8.0%
EPO HSA	BH-FZ	BQ-BF	816		\$652.85	0.5471	1.081	\$386.11	\$766.11	0.5029	\$385.28	-0.2%	7.9%	7.2%	6.6%	5.9%
EPO HSA	BH-E3	BH-E3	575		\$652.85	0.4090	1.081	\$288.64	\$766.11	0.3905	\$299.17	3.6%	12.0%	11.4%	10.7%	10.0%
EPO HSA	BH-EZ	BH-EZ	816		\$652.85	0.6346	1.081	\$447.86	\$766.11	0.6039	\$462.65	3.3%	11.7%	11.0%	10.4%	9.7%
POS	BH-E4	BQ-AM	813		\$652.85	0.6881	1.081	\$485.61	\$766.11	0.6614	\$506.71	4.3%	12.8%	12.1%	11.5%	10.8%
POS	BH-E5	BQ-AQ	845		\$652.85	0.8397	1.081	\$592.60	\$766.11	0.8272	\$633.73	6.9%	15.6%	14.9%	14.2%	13.5%
POS	BH-FF	BQ-AX	819		\$652.85	0.5977	1.081	\$421.82	\$766.11	0.5642	\$432.24	2.5%	10.8%	10.1%	9.5%	8.8%
POS	BH-FW	BQ-A3	814		\$652.85	0.7745	1.081	\$546.59	\$766.11	0.7558	\$579.03	5.9%	14.5%	13.9%	13.2%	12.5%
POS	BH-FX	BQ-A6	816		\$652.85	0.6040	1.081	\$426.26	\$766.11	0.5627	\$431.09	1.1%	9.3%	8.7%	8.0%	7.4%
POS	BH-FM	BQ-A8	816		\$652.85	0.5940	1.081	\$419.20	\$766.11	0.5627	\$431.09	2.8%	11.2%	10.5%	9.9%	9.2%
POS	BH-FQ	BQ-BA	816		\$652.85	0.6224	1.081	\$439.25	\$766.11	0.5793	\$443.81	1.0%	9.2%	8.6%	7.9%	7.3%
POS	BH-FS	BQ-BC	818		\$652.85	0.5574	1.081	\$393.37	\$766.11	0.5221	\$399.99	1.7%	9.9%	9.3%	8.6%	7.9%
POS	BH-FT	BQ-BE	818		\$652.85	0.4852	1.081	\$342.42	\$766.11	0.4549	\$348.50	1.8%	10.0%	9.4%	8.7%	8.0%
POS	BH-F3	BQ-BJ	820		\$652.85	0.8142	1.081	\$574.61	\$766.11	0.8006	\$613.35	6.7%	15.4%	14.7%	14.0%	13.3%
POS HSA	BH-EY	BQ-AO	816		\$652.85	0.7005	1.081	\$494.36	\$766.11	0.6537	\$500.81	1.3%	9.5%	8.9%	8.2%	7.5%
POS HSA	BH-FU	BQ-BG	816		\$652.85	0.5582	1.081	\$393.94	\$766.11	0.5132	\$393.17	-0.2%	7.9%	7.3%	6.6%	5.9%
POS HSA	BH-E6	BH-E6	816		\$652.85	0.6471	1.081	\$456.68	\$766.11	0.6162	\$472.08	3.4%	11.7%	11.1%	10.4%	9.7%
EPO		BQ-AZ	819		New Ben	efit Plan			\$766.11	0.4461	\$341.76					
POS		BQ-AL	A85		New Ben	efit Plan			\$766.11	0.5556	\$425.65					
POS		BQ-AN	818		New Ben	efit Plan			\$766.11	0.5683	\$435.38					
POS		BQ-AR	A85		New Ben				\$766.11	0.6681	\$511.84					
POS		BQ-AY	819		New Ben	efit Plan			\$766.11	0.4921	\$377.00					
POS		BQ-A2	819		New Ben				\$766.11	0.4540	\$347.81					
		•							-							

New 2020 Benefit Plans

		Metal	Plan
SCID	Product	Level	Name
41842DC0040065-01	EPO	Silver 19	BQ-AZ
41842DC0010085-01	POS	Gold 29	BQ-AL
41842DC0010086-01	POS	Gold 28	BQ-AN
41842DC0010087-01	POS	Plat 15	BQ-AR
41842DC0010088-01	POS	Gold 31	BQ-AY
41842DC0010089-01	POS	Silver 19	BQ-A2

Terminated 2019 Benefit Plans

		Metal	Plan
SCID	Product	Level	Name
41842DC0040063	EPO	Silver 18	BH-FH
41842DC0010083	POS	Silver 18	BH-FI

2019 Benefit Plans with Plan Changes (Uniform Modification)

		Metal	2019	2020		Value of Benefit
SCID	Product	Level	Name	Name	Benefit Plan Changes	Change on Rate
41842DC0040057-01	EPO	Gold 22	BH-E7	BQ-AK	Add PLN	0.0%
41842DC0040062-01	EPO	Gold 23	BH-FE	BQ-AW	Add PLN	0.0%
41842DC0040045-01	EPO	Gold 13	BH-FR	BQ-A5	INN ded from 1500/3000 to 1750/3500; Add PLN	-3.0%
41842DC0040064-01	EPO	Gold 26	BH-FV	BQ-A7	Add PLN	0.0%
41842DC0040091-01	EPO	Gold 8	BH-FN	BQ-A9	Add PLN	0.0%
41842DC0040059-01	EPO	Platinum 1	BH-F2	BQ-BB	Add PLN	0.0%
41842DC0040060-01	EPO	Platinum 4	BH-F5	BQ-BD	Add PLN	0.0%
41842DC0040101-01	EPO	Silver 8	BH-FY	BQ-BI	INN Ded from 2500/5000 to 2750/5500; INN OOPM from 7900/15800 to 8150/16300; Add PLN	-1.3%
41842DC0040046-01	EPO HSA	Silver 11	BH-FZ	BQ-BF	INN Ded from 2600/5200 to 2750/5500; ER from \$150 after ded to \$250 after ded; Add PLN	-2.2%
41842DC0010078-01	POS	Gold 22	BH-E4	BQ-AM	Add PLN	0.0%
41842DC0010074-01	POS	Plat 14	BH-E5	BQ-AQ	INN OOPM from 3000/6000 to 4000/8000; OON OOPM from 3000/6000 to 4000/8000	-0.6%
41842DC0010082-01	POS	Gold 23	BH-FF	BQ-AX	Add PLN	0.0%
41842DC0010066-01	POS	Platinum 1	BH-FW	BQ-A3	Add PLN	0.0%
41842DC0010032-01	POS	Gold 10	BH-FX	BQ-A6	INN OOPM from 6500/13000 to 7500/15000; ER from D&C to \$250+D&C Add PLN	-2.2%
41842DC0010054-01	POS	Gold 8	BH-FM	BQ-A8	Add PLN	0.0%
41842DC0010042-01	POS	Gold 13	BH-FQ	BQ-BA	INN ded from 1500/3000 to 1750/3500; OON ded from 3000/6000 to 4000/8000; Add PLN	-3.0%
41842DC0010084-01	POS	Gold 26	BH-FS	BQ-BC	Add PLN	0.0%
41842DC0010080-01	POS	Silver 8	BH-FT	BQ-BE	INN Ded from 2500/5000 to 2750/5500; INN OOPM from 7900/15800 to 8150/16300; OON Ded from 4000/8000 to 5000/10000; Add PLN	-1.4%
41842DC0010068-01	POS	Platinum 4	BH-F3	BQ-BJ	Add PLN	0.0%
41842DC0010006-01	POS HSA	Gold 7	BH-EY	BQ-AO	INN ded from 1500/3000 to 1750/3500; OON Ded from 2000/4000 to 3000/6000	-3.2%
41842DC0010043-01	POS HSA	Silver 11	BH-FU	BQ-BG	INN Ded from 2600/5200 to 2750/5500; ER from \$150 after ded to \$250 after ded; OON Ded from 4000/8000 to 5000/10000; Add PLN	-2.3%

Unchanged 2019 Benefit Plans - Continued into 2020

		Metal	Plan
SCID	Product	Level	Name
41842DC0040008-01	EPO HSA	Bronze 4	BH-E3
41842DC0040061-01	EPO HSA	Gold 1	BH-EZ
41842DC0010081-01	POS HSA	Gold 1	BH-E6

Rate Calculation Formula

Monthly premium =

Base Rate

x Plan ratio

x Effective date adjustment (EDA) factor for plan effective or renewal date

x Sum of member age factors for the group

Rating Example

Benefit Plan: EPO plan BQ-AK with Rx 813

Effective Date: 1/1/20

Census:

		Member A	ges		_		Age F	actors		
	EE Age	Spouse Age	Child #1	Child #2	-	<u>EE</u>	Spouse	Child #1	Child #2	
EE #1	43	41	10	15		1.094	1.013	0.654	0.654	
EE #2	35	36	5	9		0.876	0.896	0.654	0.654	
EE #3	53	55	19			1.605	1.733	0.654		

Total Members: 11 Sum of Age Factors: 10.487

Rate Calculation

	Rating Factor	Exhibit 1 Location
\$766.11	Base Rate	(1)
0.6546	Benefit Plan Ratio (BQ-	-AK w 813) (2)
1.000	EDA Factor (1Q20)	(3)
10.487	Group Age Factor	(4)
\$5.259.18		

Total Monthly Premium

				2040	2040	Current		New I		Data Changa	Revenue
License	Plan Name Metal Level	Product	Rx Plan	2018 Members	2019 Base Rate	Plan Ratio Medical	PMPM	Plan Ratio	PMPM	Rate Change by Plan	Nuetral PMPM
OCI	AE-CM	нмо	YM	761	640.65	0.7721	494.62	0.7646	489.82	1.8%	503.39
OCI	AJ-EU	HMO	ZR	1182	640.65	0.7747	496.31	0.7668	491.23	1.7%	504.84
OCI OCI	AJ-ET AM-4N	HMO HMO	ZU YM	636 263	640.65 640.65	0.8216 0.6000	526.37 384.36	0.8149 0.5720	522.09 366.43	1.9% -2.0%	536.55 376.58
OCI	AL-EJ	HMO	YM	720	640.65	0.6106	391.15	0.5852	374.89	-1.5%	385.27
OCI	AL-EL	HMO	YM	313	640.65	0.6734	431.43	0.6485	415.43	-1.0%	426.94
OCI OCI	AL-EK	HMO	YM YM	460 1330	640.65 640.65	0.5466	350.19	0.5142 0.7646	329.43	-3.3%	338.55 503.39
UHCMA	AX-BB AL-EI	HMO HMO	YM	93	586.40	0.7721 0.6106	494.62 358.03	0.5852	489.82 343.14	1.8% -1.5%	352.65
UHCMA	AL-DS	HMO	YM	348	586.40	0.6106	358.03	0.5852	343.14	-1.5%	352.65
UHCMA	AL-D2	HMO	YM	50	586.40	0.6734	394.89	0.6485	380.26	-1.0%	390.79
UHCMA	AL-DO	HMO	YM	63	586.40	0.6734	394.89	0.6485	380.26	-1.0%	390.79
UHCMA UHCMA	AL-FH AL-FG	HMO HMO	D0 D0	65 124	586.40 586.40	0.4934 0.4934	289.35 289.35	0.4662 0.4662	273.37 273.37	-2.9% -2.9%	280.95 280.95
UHCMA	AL-DT	HMO	YM	77	586.40	0.5466	320.53	0.5142	301.53	-3.3%	309.88
UHCMA	AL-DM	HMO	YM	94	586.40	0.5466	320.53	0.5142	301.53	-3.3%	309.88
UHCMA	AL-DU	HMO	YM	13	586.40	0.4126	241.92	0.3934	230.68	-2.0%	237.07
UHCMA UHIC	AL-DN AD-7H	HMO POS	YM YM	178 6259	586.40 652.85	0.4126 0.7835	241.92 511.52	0.3934 0.7761	230.68 506.69	-2.0% 1.8%	237.07 520.72
UHIC	AJ-EV	POS	ZR	2694	652.85	0.7852	512.59	0.7773	507.46	1.7%	521.51
UHIC	6Y-5	POS	ZV	2515	652.85	0.7487	488.82	0.7415	484.09	1.8%	497.50
UHIC	AJ-EW	POS	ZU ZV	7167	652.85	0.8339	544.40	0.8272	540.06	2.0%	555.02
UHIC	AJ-EX AJ-EY	POS POS	ZU	4412 1642	652.85 652.85	0.7973 0.8213	520.52 536.20	0.7891 0.8138	515.20 531.29	1.7% 1.8%	529.47 546.01
UHIC	AD-69	POS	263	2049	652.85	0.8394	548.02	0.8322	543.32	1.9%	558.37
UHIC	AL-DI	POS	263	736	652.85	0.8207	535.78	0.8124	530.39	1.7%	545.08
UHIC	AL-DJ	POS	263	5491	652.85	0.8441	551.10	0.8372	546.54	1.9%	561.68
UHIC	AL-DC AL-C9	POS POS	YM YM	1384 6093	652.85 652.85	0.6649 0.6976	434.07 455.41	0.6355 0.6714	414.90 438.34	-1.8% -1.1%	426.39 450.48
UHIC	60-J	EPO	YM	404	652.85	0.6000	391.68	0.5720	373.40	-2.0%	383.75
UHIC	60-K	POS	YM	927	652.85	0.6114	399.12	0.5834	380.89	-1.9%	391.44
UHIC	AL-DX	POS	YM	2013	652.85	0.6323	412.82	0.6077	396.76	-1.2%	407.75
UHIC	AL-DY AL-D1	POS EPO	YM YM	4716 954	652.85 652.85	0.6219 0.6734	406.03 439.64	0.5966 0.6485	389.50 423.35	-1.4% -1.0%	400.29 435.07
UHIC	AL-DZ	POS	YM	522	652.85	0.6860	447.85	0.6609	431.45	-1.0%	443.40
UHIC	AL-JF	EPO	YM	1088	652.85	0.6549	427.57	0.6416	418.90	0.7%	430.50
UHIC	AL-JG	POS	YM	2756	652.85	0.6666	435.19	0.6534	426.56	0.7%	438.37
UHIC	AL-FF AL-C8	EPO EPO	ZT YM	95 439	652.85 652.85	0.5879 0.5433	383.83 354.72	0.5614 0.5130	366.51 334.92	-1.9% -3.0%	376.67 344.20
UHIC	AL-DA	POS	YM	575	652.85	0.5546	362.07	0.5241	342.18	-2.9%	351.65
UHIC	AL-DB	POS	YM	1051	652.85	0.5165	337.22	0.4920	321.19	-2.1%	330.09
UHIC	AL-DV	EPO	D0	170	652.85	0.4934	322.14	0.4662	304.35	-2.9%	312.78
UHIC	AL-DW AL-D3	POS EPO	D0 ZT	647 421	652.85 652.85	0.5030 0.5038	328.37 328.93	0.4758 0.4755	310.62 310.42	-2.8% -3.0%	319.22 319.02
UHIC	AL-JI	EPO	YM	626	652.85	0.5466	356.85	0.5142	335.70	-3.3%	345.00
UHIC	AL-JH	POS	YM	936	652.85	0.5580	364.28	0.5255	343.05	-3.2%	352.55
UHIC	AL-FE	EPO	ZT	23	652.85	0.4835	315.67	0.4606	300.71	-2.1%	309.04
UHIC OCI	AL-JD AT-1A	EPO HMO	YM 684	94 2037	652.85 640.65	0.4126 0.7675	269.34 491.69	0.3934 0.7481	256.82 479.29	-2.0% 0.2%	263.94 492.57
OCI	AT-Z9	HMO	010	1172	640.65	0.8021	513.87	0.7481	505.20	1.0%	519.20
OCI	AT-1C	нмо	010	559	640.65	0.7931	508.07	0.7715	494.29	0.0%	507.98
OCI	AT-1B	HMO	591	748	640.65	0.5996	384.15	0.5712	365.95	-2.1%	376.08
OCI OCI	AT-Z8 AT-Z3	HMO HMO	591 723	67 396	640.65 640.65	0.6755 0.6812	432.77 436.40	0.6507 0.6541	416.85 419.02	-1.0% -1.3%	428.39 430.63
OCI	AT-Z7	HMO	591	185	640.65	0.5479	351.00	0.5153	330.11	-3.3%	339.25
OCI	AT-Z6	нмо	724	136	640.65	0.5876	376.44	0.5402	346.09	-5.5%	355.68
UHCMA	AT-ZN	HMO	591	690	586.40	0.6044	354.44	0.5780	338.93	-1.7%	348.32
UHCMA UHCMA	AT-ZF AT-ZL	HMO HMO	591 591	1475 64	586.40 586.40	0.6044 0.6755	354.44 396.13	0.5780 0.6507	338.93 381.55	-1.7% -1.0%	348.32 392.12
UHCMA	AT-ZE	HMO	591	400	586.40	0.6755	396.13	0.6507	381.55	-1.0%	392.12
UHCMA	AT-Z1	HMO	593	278	586.40	0.4938	289.59	0.4673	274.03	-2.8%	281.62
UHCMA	AT-ZG	HMO	593	237	586.40	0.4938	289.59	0.4673	274.03	-2.8%	281.62
UHCMA	AT-ZH	HMO	591	75	586.40	0.5479	321.28	0.5153	302.15	-3.3%	310.52
UHCMA UHCMA	AT-ZD AT-YW	HMO HMO	591 575	332 30	586.40 586.40	0.4835 0.4102	283.52 240.52	0.4601 0.3914	269.82 229.54	-2.2% -1.9%	277.29 235.90
UHCMA	AT-ZB	HMO	575	372	586.40	0.4102	240.52	0.3914	229.54	-1.9%	235.90
UHCMA	AT-YY	HMO	725	45	586.40	0.4445	260.67	0.4198	246.14	-3.0%	252.96
UHCMA	AT-ZC	HMO	725	21	586.40	0.4445	260.67	0.4198	246.14	-3.0%	252.96
UHIC	AT-ZX AT-ZO	EPO POS	684 684	429 5670	652.85 652.85	0.7675 0.7792	501.06 508.68	0.7481 0.7599	488.42 496.07	0.2% 0.2%	501.95 509.82
UHIC	AT-YT	POS	590	2009	652.85	0.7354	480.10	0.7283	475.50	1.8%	488.67
UHIC	AT-ZY	EPO	010	735	652.85	0.8021	523.66	0.7886	514.82	1.0%	529.08
UHIC	AT-ZR	POS	010	6537	652.85	0.8143	531.61 525.71	0.8008	522.80	1.1%	537.28 525.87
UHIC	AT-ZS AT-ZA	POS POS	010 263	9057 5310	652.85 652.85	0.8053 0.8339	525.71 544.43	0.7838 0.8263	511.69 539.43	0.0% 1.8%	525.87 554.38
UHIC	AT-YS	POS	591	5385	652.85	0.7026	458.71	0.6776	442.37	-0.9%	454.62
UHIC	AT-ZP	EPO	591	1134	652.85	0.5996	391.47	0.5712	372.92	-2.1%	383.25
UHIC	AT-ZQ AT-ZI	POS POS	591 591	1906 6918	652.85 652.85	0.6110 0.6152	398.91 401.65	0.5827 0.5889	380.40 384.44	-2.0% -1.6%	390.94 395.09
UHIC	AT-ZK	EPO	591	1108	652.85	0.6321	401.65	0.5889	392.01	-1.6%	395.09 402.87
UHIC	AT-ZJ	POS	591	3463	652.85	0.6881	449.23	0.6631	432.90	-1.0%	444.89
UHIC	AT-ZT	EPO	591	2545	652.85	0.6378	416.38	0.6062	395.75	-2.3%	406.71
UHIC	AT-ZU AT-YV	POS EPO	591 593	7308 649	652.85 652.85	0.6486 0.5842	423.47 381.39	0.6171 0.5580	402.89 364.29	-2.2% -1.8%	414.05 374.38
UHIC	AT-YZ	EPO	593 726	649 618	652.85 652.85	0.5842	381.39 379.21	0.5580	364.29 359.30	-1.8% -2.6%	3/4.38 369.25
UHIC	AT-Y1	POS	726	834	652.85	0.5903	385.39	0.5599	365.51	-2.5%	375.64
UHIC	AT-Y6	EPO	723	670	652.85	0.6812	444.71	0.6541	427.00	-1.3%	438.83
UHIC	AT-Y7 AT-ZM	POS EPO	723 593	1485 598	652.85 652.85	0.6879 0.4938	449.12 322.41	0.6609 0.4673	431.44 305.09	-1.3% -2.8%	443.39 313.54
UHIC	AT-ZM AT-ZZ	POS	593 593	598 849	652.85 652.85	0.4938	322.41 328.63	0.4673	305.09 311.35	-2.8% -2.6%	313.54 319.98
UHIC	AT-ZW	EPO	591	863	652.85	0.5479	357.69	0.5153	336.39	-3.3%	345.71
UHIC	AT-ZV	POS	591	1160	652.85	0.5590	364.91	0.5262	343.53	-3.3%	353.04
UHIC	AT-YU AT-Y2	EPO EPO	593 726	143 121	652.85 652.85	0.4822 0.4824	314.77 314.96	0.4598 0.4609	300.19 300.89	-2.0% -1.8%	308.50 309.23
UHIC	AT-Y2 AT-Y3	POS	726 726	121 277	652.85 652.85	0.4824	314.96 319.78	0.4609	300.89 305.75	-1.8% -1.7%	309.23 314.21
UHIC	AT-Y4	EPO	726	90	652.85	0.4743	309.62	0.4514	294.67	-2.2%	302.83
UHIC	AT-Y5	POS	726	120	652.85	0.4817	314.45	0.4588	299.54	-2.1%	307.83
UHIC	AT-Y8 AT-Y9	EPO POS	724 724	66 305	652.85 652.85	0.5876 0.5943	383.61 387.98	0.5402 0.5469	352.68 357.07	-5.5% -5.4%	362.45 366.96
UHIC	AT-YX	EPO	724 575	305 234	652.85 652.85	0.5943	387.98 267.77	0.5469	357.07 255.55	-5.4% -1.9%	366.96 262.63
		-								,	
						embership in		143,584			143,584
					PMPM using the PMPM using the PMPM using			\$463.76 \$451.26	Cı	urrent Revenue: New Revenue:	\$ 66,588,908 \$ 66,588,908
				Average r		g the new price e Neutrality A		2.8%	Cha	new Revenue:	\$ 66,588,908 0.0%

Cost Sharing Design of Plan

	BQ-A3	BQ-BJ	BQ-AQ	BQ-AR	BQ-AO	BQ-A6	BQ-BA	BQ-A8	BQ-AM	BH-E6	BQ-AX	BQ-BC	BQ-AL	BQ-AN	BQ-AY	BQ-BG	BQ-BE	BQ-A2	BQ-BB	BQ-BD	BQ-A5	BQ-AK	BH-EZ	BQ-AW	BQ-A7	BQ-A9	BQ-BF	BQ-AZ	BQ-BI	BH-E3
Actuarial value and cost-sharing design of the																														
plan (From the URRT)	0.941	0.997	1.030	0.832	0.814	0.700	0.721	0.700	0.823	0.767	0.702	0.650	0.692	0.707	0.613	0.639	0.566	0.565	0.926	0.981	0.709	0.815	0.752	0.690	0.638	0.687	0.626	0.555	0.556	0.486
Paid/Allowed Ratio (Cost-Sharing only)	0.724	0.767	0.792	0.640	0.695	0.599	0.616	0.599	0.704	0.656	0.600	0.555	0.591	0.605	0.524	0.592	0.524	0.523	0.713	0.755	0.606	0.696	0.643	0.590	0.545	0.587	0.580	0.514	0.514	0.486
Used Induced utilization factors	1.300	1.300	1.300	1.300	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.080	1.080	1.080	1.300	1.300	1.170	1.170	1.170	1.170	1.170	1.170	1.080	1.080	1.080	1.000
Calculated	0.941	0.996	1.030	0.832	0.814	0.700	0.721	0.700	0.823	0.767	0.702	0.650	0.691	0.707	0.612	0.639	0.566	0.565	0.926	0.981	0.709	0.815	0.752	0.690	0.638	0.687	0.626	0.555	0.556	0.486

Member Months, Earned Premium & Incurred Claim Experience - UHIC

		Earned	Incurred	Risk	Claim	Risk Adj.	Galaxy
<u>Month</u>	<u>Members</u>	<u>Premium</u>	<u>Claims</u>	<u>Adjustment</u>	<u>PMPM</u>	Loss Ratio	Rx Rebate
Jan-16	7,809	3,353,774	2,153,981	-5.1%	275.83	67.7%	(140,886)
Feb-16	7,812	3,351,827	3,004,471	-5.1%	384.60	94.5%	(154,577)
Mar-16	7,785	3,353,929	2,249,265	-5.1%	288.92	70.7%	(172,682)
Apr-16	7,926	3,421,270	2,478,744	-5.1%	312.74	76.3%	(170,024)
May-16	8,015	3,459,521	2,519,209	-5.1%	314.31	76.7%	(142,711)
Jun-16	8,119	3,518,895	2,369,236	-5.1%	291.81	70.9%	(166,726)
Jul-16	8,182	3,564,006	2,281,331	-5.1%	278.82	67.5%	(148,666)
Aug-16	8,310	3,632,483	2,516,157	-5.1%	302.79	73.0%	(170,589)
Sep-16	8,284	3,671,810	2,484,192	-5.1%	299.88	71.3%	(165,862)
Oct-16	8,188	3,664,223	2,458,794	-5.1%	300.29	70.7%	(146,466)
Nov-16	8,140	3,565,311	2,623,538	-5.1%	322.30	77.5%	(165,211)
Dec-16	8,562	3,861,090	2,413,240	-5.1%	281.85	65.9%	(167,575)
Jan-17	8,504	3,812,114	2,742,140	3.3%	322.45	69.6%	(171,916)
Feb-17	8,679	3,878,597	3,077,906	3.3%	354.64	76.8%	(178,355)
Mar-17	8,749	3,886,716	3,138,112	3.3%	358.68	78.1%	(192,976)
Apr-17	8,705	3,848,681	2,662,877	3.3%	305.90	67.0%	(173,815)
May-17	8,803	3,883,853	3,390,904	3.3%	385.20	84.5%	(206,321)
Jun-17	8,824	3,872,150	3,945,739	3.3%	447.16	98.6%	(193,353)
Jul-17	8,796	3,865,787	4,070,851	3.3%	462.81	101.9%	(195,995)
Aug-17	8,850	3,886,257	3,380,706	3.3%	382.00	84.2%	(184,826)
Sep-17	8,776	3,836,894	2,922,937	3.3%	333.06	73.7%	(182,476)
Oct-17	8,875	3,894,442	3,070,879	3.3%	346.01	76.3%	(221,965)
Nov-17	9,047	3,953,139	3,744,435	3.3%	413.89	91.7%	(189,532)
Dec-17	9,382	4,144,177	3,371,601	3.3%	359.37	78.7%	(217,682)
Jan-18	9,792	4,336,579	3,630,836	1.9%	370.80	82.2%	(226,686)
Feb-18	9,871	4,366,553	3,327,527	1.9%	337.10	74.8%	(213,188)
Mar-18	9,948	4,395,040	3,890,612	1.9%	391.09	86.9%	(239,074)
Apr-18	10,073	4,430,048	4,123,093	1.9%	409.32	91.3%	(231,950)
May-18	10,212	4,491,004	3,675,708	1.9%	359.94	80.3%	(273,120)
Jun-18	10,566	4,648,872	3,722,396	1.9%	352.30	78.6%	(282,577)
Jul-18	10,766	4,698,864	3,768,899	1.9%	350.07	78.7%	(246,624)
Aug-18	10,879	4,789,252	3,582,646	1.9%	329.32	73.4%	(290,001)
Sep-18	11,021	4,854,251	3,788,872	1.9%	343.79	76.6%	(264,711)
Oct-18	11,299	5,018,673	3,728,515	1.9%	329.99	72.9%	(255,066)
Nov-18	11,342	5,050,263	4,455,111	1.9%	392.80	86.6%	(284,193)
Dec-18	11,694	5,078,948	4,394,519	1.9%	375.79	84.9%	(262,140)
2018 Total	127,463	56,158,345	46,088,734	1.9%	361.59	80.5%	(3,069,330)

Certification for AV Calculator Exhibit B

Estimation of fit of plan design into the parameters of AV calculator

Metallic Plan (e)	INN Coins	OP Copay Free Standing	OP Copay Hospital	Imaging (CT/PET Scans, MRIs) Free Standing	Imaging (CT/PET Scans, MRIs) Hospital	Imaging (CT/PET Scans, MRIs)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Specialty Drugs (i.e. high-cost)	Methodology
Bronze 4	100%	D&C	D&C	D&C	D&C			\$0.00	c,d
Silver 8	70%	\$300	D&C	\$300	D&C	56.2%/D&C	32.8%/D&C	\$120.00	b,c,d
Silver 11	100%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/63.5%	D&C/44.0%	\$120.00	a, b, c, d
Silver 19	70%	D&C	D&C	D&C	D&C			\$120.00	c,d
Gold 1	90%	D&C	D&C	D&C	D&C			\$120.00	c,d
Gold 7	100%	D&C	D&C	D&C	D&C			\$120.00	c,d
Gold 8	80%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/50.4%	D&C/33.9%	\$120.00	a,b,c,d
Gold 10	80%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/50.4%	D&C/33.9%	\$120.00	a,b,c,d
Gold 13	100%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/63.0%	D&C/42.4%	\$120.00	a,b,c,d
Gold 23	80%	D&C	D&C	\$500	\$500		·	\$120.00	c,d
Gold 26	100%	\$150+D&C	\$300+D&C	\$150+D&C	\$300+D&C	77.8%/55.6%	65.4%/30.8%	\$120.00	a,b,c,d
Gold 28	70%	Coins Only	Coins Only	Coins Only	Coins Only			\$120.00	c,d
Gold 29	80%	D&C	D&C	D&C	D&C			\$0.20	c,d
Gold 31	80%	D&C	D&C	D&C	D&C			\$120.00	c,d
Platinum 1	100%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/60.7%	D&C/40.4%	\$100.00	a,b,c,d
Platinum 4	100%	\$0	\$150	\$0	\$150	FS vs. H Run	FS vs. H Run	\$100.00	b,c,d
Platinum 15	80%	Coins Only	Coins Only	Coins Only	Coins Only			\$0.20	c,d

Methodology

- a) An effective coinsurance for Per-Occurrence Deductibles on Imaging services and Outpatient facility fee was calculated based on unit costs derived from
- UnitedHealthcare's proprietary pricing model.

 b) Actuarial Value is the blend of Free-Standing and Hospital setting run, where weight of Free Standing and Hospital Setting are adjusted based on actual utilization of free standing and hospital facilities by service categories.

 c) Speciality Rx: Entered the Rx Tier cost share with the highest specialty drug utilization per UnitedHealthcare's proprietary
- pricing model.
 d) See Exhibit 2 for plan benefit description, and for tie-in to benefit plan name.

For plan design features that do not fit into the parameters of the AV Calculator, I certify that both the methodology and the calculated estimated values are in accordance with generally accepted actuarial principles and methodologies. Ryan Morgan

Ryan Morgan, FSA, MAAA

DC Small Group Rate Review - Development of Underwriting Loss Ratio Total for UHIC, UHCMA, and OCI

Experience 1/1/2018-12/31/2018	Total
1a. Member Months	143,511
1b. Incurred Claims	\$50,081,602
1c. Claim PMPM (1b/1a)	\$348.97
1d. Catastrophic Claims Adjustment PMPM	\$2.06
1e. Adjusted Claim PMPM (1c+1d)	\$351.03
1f. Earned Premium	\$62,255,352
1g. Premium PMPM (1f/1a)	\$433.80
1h. Adjusted Benefit Ratio (1e/1g)	80.9%
2a. Claim trend	1.181
From center of experience period: 7/1/18	
to average center of 1/1/19 pricing period: 7/1/20, 8/1/20, 9/1	L/20
(25 months at 8.3% annual rate)	
2b. Deductible Maturity adjustment	1.01
2c. Claim cost subtotal (1c x 2a x 2b)	\$418.61
2d. Admin, Profit & Taxes	\$108.18
Admin	\$41.17
Commissions	\$13.82
Taxes	\$37.36
Profit	\$15.82
2e. Needed revenue PMPM before risk adjustment (2c + 2d)	\$526.79
2g. Risk Adjustment (2.7% Payer)	\$14.55
2f. Needed Revenue PMPM after risk adjustment (2e + 2f)	\$541.34
3a. DC SG Trended Base Rate	\$720.42
3b. Proposed Base Rate Increase (3.1%)	1.031
3c. Current Average Med Plan Rel	0.7095
3d. Current Average Age Factor	1.027
3e. Current premium PMPM for 1/1/20 effective date	
(3a x 3b x 3c x 3d)	\$541.34
4. Estimated Underwriting Loss Ratio (2c/2e)	79.5%



Healthcare Economics

WASHINGTON DC SMALL GROUP PRICING TREND DEVELOPMENT APRIL 2019 RATE FILING SUPPORT

	WA	SHINGTON DO	C SMALL GRO	OUP PRICING T	TREND BY	COMPONENT			
	Notes:	<u>Inpatient</u>	Outpatient	Professional	Other	<u>Capitation</u>	Total <u>Medical</u>	Retail <u>Pharmacy</u>	Weighted <u>Aggregate</u>
Component Summary									
Utilization / Service Mix	[1],[2]	3.7%	4.2%	2.7%	0.4%	0.0%	3.2%	3.9%	3.3%
Unit Cost	[3]	4.8%	4.9%	3.0%	1.0%	3.3%	4.0%	4.8%	4.1%
Demographic Change	[5]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Benefit Leveraging	[4]	0.1%	0.6%	1.0%	0.3%	0.0%	0.5%	1.0%	0.6%
Margin		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Proposed Pricing Trend	[6]	8.8%	9.9%	6.8%	1.7%	3.3%	7.9%	9.9%	8.3%
Service Weight - Washington Dc		22.5%	25.1%	24.3%	5.7%	2.5%	80.1%	19.9%	100.0%

Notes:

- [1] Represents core utilization only, exclusive of demographic change impacts; includes expected impact of changes in business day content.
- [2] Represents expected changes in intensity of services provided.
- [3] Represents core unit pricing increases, exclusive of service mix / intenisty of services impact;
- [4] Impact of member cost-share leveraging on net claims cost trend.
- [5] Represents trend impact of age and gender changes; No provision included for Small Group business (age/gender community rating variable).
- [6] Pricing models do not distinguish between Primary and Specialty medical care; same trends shown for both.

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Supporting Document Schedules

Satisfied - Item:	Actuarial Justification		
Comments:			
Attachment(s):	DC_41842_UHIC_SG_PartIII_2020Q1_v1.pdf		
Item Status:			
Status Date:			
Satisfied - Item:	Actuarial Memorandum		
Comments:			
Attachment(s):	DC-SG-UHIC-ActMemo-2020-01-v1.pdf		
Item Status:			
Status Date:			
Satisfied - Item:	Actuarial Memorandum and Certifications		
Comments:			
Attachment(s):	DC_41842_UHIC_SG_PartIII_2020Q1_v1.pdf		
Item Status:			
Status Date:			
Bypassed - Item:	Certificate of Authority to File		
Bypass Reason:	NA NA		
Attachment(s):			
Item Status:			
Status Date:			
Bypassed - Item:	Consumer Disclosure Form		
Bypass Reason:	NA NA		
Attachment(s):			
Item Status:			
Status Date:			
Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):	DC-SG-UHIC-Cover-2020-01-v1.pdf		
Item Status:			
Status Date:			

SERFF Tracking #: UHLC-131909980 State Tracking #: Company Tracking #: District of Columbia Filing Company: UnitedHealthcare Insurance Company State: TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other DC-SG-UHIC-2020-01 Product Name: Project Name/Number: Satisfied - Item: **DISB Actuarial Memorandum Dataset** Comments: Attachment(s): DC-SG-UHIC-ActuarialDataset-2020-01-v2.xlsx **Item Status:** Status Date: Bypassed - Item: District of Columbia and Countrywide Experience for the Last 5 Years (P&C) **Bypass Reason:** NA Attachment(s): **Item Status:** Status Date: Bypassed - Item: District of Columbia and Countrywide Loss Ratio Analysis (P&C) **Bypass Reason:** NA Attachment(s): Item Status: Status Date: Satisfied - Item: Unified Rate Review Template Comments: 2020 UHIC URRT v1.pdf Attachment(s): 2020 UHIC URRT v1.xlsm **Item Status:** Status Date: Satisfied - Item: District of Columbia Plain Language Summary Comments: Attachment(s): DC-SG-UHIC-PlainLanguageSummary-2020-01-v2.pdf Item Status: **Status Date:** Satisfied - Item: Rate Review Checklist Comments: Attachment(s): DC-SG-Checklist-2020.pdf

Item Status: Status Date:

Company Tracking #: SERFF Tracking #: UHLC-131909980 State Tracking #: District of Columbia State: Filing Company: UnitedHealthcare Insurance Company TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other Product Name: DC-SG-UHIC-2020-01 Project Name/Number: Satisfied - Item: AV Screenshots Comments: Attachment(s): AV Screenshots_UHIC_2020_01.pdf **Item Status: Status Date:** Satisfied - Item: Risk Adjustment RATEE Data Comments: DC Confidentiality Cover Letter EDGE Data 5.24.19.pdf 41842.RATEE.D20190503T004836.P.xml Attachment(s): **Item Status:**

Status Date:

SERFF Tracking #: UHLC-131909980 State Tracking #: Company Tracking #: Company Tracking #:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Attachment DC-SG-UHIC-ActuarialDataset-2020-01-v2.xlsx is not a PDF document and cannot be reproduced here.

Attachment 2020_UHIC_URRT_v1.xlsm is not a PDF document and cannot be reproduced here.

Attachment 41842.RATEE.D20190503T004836.P.xml is not a PDF document and cannot be reproduced here.

Federal Rate Filing Justification Part III Actuarial Memorandum and Certification

UnitedHealthcare Insurance Company

NAIC: 0707-41842

FEIN: 362739571

State of District of Columbia Rate Review

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Section 1: Purpose

The following is a rate filing prepared by UnitedHealthcare Insurance Company. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services and the state of District of Columbia. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template (URRT).

This filing establishes rates intended to be used for non-grandfathered PPACA compliant small group health benefit plans sold on the Small Business Health Options Program in District of Columbia for the 2020 plan year. A rate increase is being filed at this time. The rates and other information in this submission are based on the current regulations and guidance from HHS. Changes to this filing may be necessary if there are revisions to the regulations or updated guidance from HHS.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the District of Columbia Department of Insurance and Financial Services. It will demonstrate compliance with state and federal laws and regulations related to the development of the index rate and allowable rating factors and is not intended to be used for any other purpose.

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by D.C. Code section 31-3303.08(b) and D.C. Code section 2-534(a)(1). If the prohibition against disclosure by the Department of Insurance and Financial Services is reassessed at a later date, it may not be disclosed to any other state or federal regulatory agencies unless the recipient agrees in writing prior to receipt to maintain the confidentiality of the information.

Section 2: General Information

Company Identifying Information

Company Legal Name: UnitedHealthcare Insurance Company

State: District of Columbia

HIOS Issuer ID: 41842

Market: Small Business, 1-50
Proposed Effective Date: January 01,2020

Primary Contact Information

Name: Ryan Morgan, FSA, MAAA

Telephone Number: 414-443-4287

Email Address: ryan_morgan2@uhc.com

Section 3: Proposed Rate Changes

The proposed change in rates for this filing is 11.24% compared to the prior filing. These changes are applied uniformly to all plans within a rating area. The proposed pricing trend is 8.29% annually.

The primary drivers of the proposed rate changes are the following:

- Changes in medical service costs
 - Increasing Cost of Medical Services Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
 - Increased Utilization The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
 - O Higher Costs from Deductible Leveraging Health care costs continue to rise every year. If deductibles and copayments remain the same, a greater percentage of health care costs need to be covered by health insurance premiums each year.
 - Cost shifting from the public to the private sector Reimbursements from the Center for Medicare
 and Medicaid Services (CMS) to hospitals do not generally cover all of the cost of care. The cost
 difference is being shifted to private health plans. Hospitals typically make up this difference by
 charging private health plans more.
 - Impact of New Technology Improvements to medical technology and clinical practice often result in the use of more expensive services - leading to increased health care spending and utilization.
- Administrative costs and anticipated profit
 - UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.
 - Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.
 - State and/or Federal government imposed taxation and fees are additional significant factors that impact health care spending. These fees include ACA taxes and fees which will have increased health insurance costs and need to be reflected in premium.
- Changes that vary by plan
 - All plan relativity factors have been updated to reflect UnitedHealthcare's most recent pricing model.
 - The impact of any changes to plans that have occurred due to uniform modification are also reflected in the updated plan relativity factors. Please see the "Plan Adjusted Index Rate" section of the memorandum for more detail on these changes.

We refined the medical and pharmacy plan price relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing by the estimated value of the benefits and the expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status. The net impact of all changes by plan can be found in Worksheet 2, Section I of the Unified Rate Review Template.

Significant factors driving the proposed rate changes are discussed in further detail in Section 6 (*Projection Factors*) and Section 7 (*Credibility Manual Rate Development*) of this memorandum.

Section 4: Experience and Current Period Premium, Claims and Enrollment

Paid Through Date

The experience period is 1/1/2018 through 12/31/2018, with claims paid through 2/28/2019.

Current Date

The current enrollment and premium is reported as of 12/31/2018.

Support for estimate of incurred but not paid claims

Historical claims are categorized both by the month in which they were incurred and the month in which they were adjudicated. For incurral months with sufficient adjudicated claim experience, incurred claims are estimated by applying completion factors derived from the historical claims. Adjustments are made based on specific knowledge of the entity (e.g., catastrophic claims, pended claims, etc.). For incurral months where adjudicated claim experience is not sufficient to rely on completion factors, a PMPM is used to estimate incurred claims. PMPM estimates are based on expected claim seasonality patterns, monthly calendar days and work days, emerging claim trends, and other factors.

The same completion factors are applied to both incurred and allowed claims amounts.

Experience Period Risk Adjustment

Risk Adjustments for the experience period are not known at this time.

Our 2018 risk adjustment transfer PMPM is estimated using data provided to UnitedHealthcare as a result of our participation in a multi-state study done by a large, independent actuarial consulting firm. Based on the results of that study, we expect that risk level of the membership insured by UnitedHealthcare Insurance Company to be lower than the market. This results in an approximate adjustment of \$5.66 PMPM.

Experience Period Index Rates

Experience Period Index Rates are defined as the allowed claims PMPM for Essential Health Benefits during the Experience Period. With the introduction of the URRT 5.0 and the breakout of service level EHB claims, the information provided reflects a reasonable estimate of the EHBs.

Section 5: Benefit Categories

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered. The benefit categories were defined by our claims department using standard industry definitions.

Inpatient Hospital

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital

Includes non-capitated facility services for surgical, emergency room, laboratory, radiology, therapeutic, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional

Includes non-capitated primary care, specialist care, therapeutic, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical

Includes non-capitated ambulatory, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other services.

Capitation

Includes all services provided under one or more capitated agreements.

Prescription Drug

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

Section 6: Projection Factors

Trend

Two years of annual trend were applied to our 2018 experience to project it to the 2020 rating period. Our most recent analysis indicates annual trend in the state of District of Columbia for the 2019 and 2020 calendar years will be 8.1% and 8.3%, respectively. The table below details the components of each trend factor.

Trend Component	2019	2020
Unit Cost	3.90%	4.10%
Utilization	3.30%	3.30%
Total	8.10%	8.30%

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected. Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macroeconomic data is often used to develop assumptions regarding directional changes in national health care consumption rates. UnitedHealthcare uses same store analysis to reflect utilization.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence the mix of procedures. Unit cost is based on our contractual changes with providers.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Section 7: Credibility Manual Rate Development

Adjustments Made to the Data

Adjustments similar to the ones described in Section 6 were applied to the experience of the credibility manual to project it to the projection period. In addition, the credibility manual was adjusted to reflect the average age, geography, plan design and morbidity of the adjusted experience period claims.

Inclusion of Capitation Payments

Capitation payments are included in both the experience and projections.

Section 8: Credibility of Experience

The experience for this legal entity contains 127,463 member months which does not exceed the 360,000 member months needed to be considered fully credible. As such the credibility of UnitedHealthcare Insurance Company is set to 0%, and the remaining uses the credibility manual described above.

Consideration was given to ASOP #25 when determining the credibility and appropriateness of the experience and the manual rate. The manual rate is sufficiently independent from the experience and can be blended with it for purposes of rate development.

Section 9: Development of Projected Index Rate

The experience period index rate is \$408.45 PMPM.

The Index Rate For the experience period is approximately 98.52% of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly. The Index Rate in the projection period represents 98.52% of allowed claims due to the benefits in excess of EHBs.

The projected index rate of \$484.48 was calculated by trending and adjusting the experience period index rate to the projection period, including blending the experience with a manual rate if the experience was not fully credible. It is established in accordance with the requirements of 45 CFR §156.80(d). See sections 6, 7, and 8 of this memo for more details.

Section 10: Development of the Market-wide Index Rate

Reinsurance

There is no reinsurance program in force for this business, and as a result there are no reinsurance recoveries to report.

Risk Adjustment Payment/Charge

UnitedHealthcare Insurance Company anticipates paying for risk adjustment transfers in the state of District of Columbia for the 2020 plan year, which has been grossed up to \$13.03 PMPM on an allowed basis for purposes of calculating the Market-wide Adjusted Index Rate. We are assuming the risk level of our business relative to that of our competitors for the 2020 plan year will be similar to what it was in the 2018 plan year. Since risk adjustment transfer payments are a function of the market level premium, our 2020 risk adjustment transfer PMPM amount is calculated by adjusting our estimated 2018 risk adjustment transfer PMPM amount for the projected market level trend, changes in reinsurance fees and recoveries, and other adjustments based on the overall financial performance of the market.

Exchange User Fees

Marketplace user fees are applied as an adjustment to the Index Rate at the market level. The value reflects the expected mix of Marketplace and non-Marketplace enrollees.

The market adjusted index rate includes market-wide adjustments for reinsurance, risk adjustment transfers and exchange user fees (if any).

	Net Federal or	Risk Adjustment	Exchange Fee	
Index Rate	State Reinsurance	Payment/Charge	Adjustment	Market Adjusted
	(allowed basis)	(allowed basis)	(allowed basis)	Index Rate
\$484.48	\$0.00	(\$13.03)	0.00%	\$497.51

The figures above may not tally exactly due to rounding of the display.

Section 11: Plan Adjusted Index Rate

Actuarial Value and Cost Sharing Adjustment

UnitedHealthcare has a proprietary pricing model that was used in developing the actuarial value and cost sharing adjustment for each plan. The model calculates plan relativity factors for medical and pharmacy benefits. Also included under the actuarial value and cost sharing adjustment are adjustments for leveraging and the difference between the average plan relativity factor and the projected paid to allowed ratio.

UnitedHealthcare Insurance Company does not utilize Induced Demand factors in our rate development. Instead, our plan-specific pricing factors are based on an analysis of UnitedHealthcare Insurance Company's nationwide block of Small Group health insurance, which reflects over 10 million member months of experience. Our approach complies with the prohibition of rating for morbidity differences by normalizing out the cost differences attributable to morbidity as measured by HHS's risk adjustment mechanism.

Historical UnitedHealthcare experience was used to develop the actuarial value and cost sharing adjustment.

Provider network, delivery system and utilization management adjustment

Any adjustments for these items are included in the plan relativity factors.

Distribution and Administrative Costs

Distribution and administrative costs include premium tax, risk adjustment user fees, SG&A, quality improvements, federal income tax, and after-tax income. Risk adjustment transfers, net reinsurance recoveries and exchange fees are excluded because they are accounted for in the market adjusted index rate.

Administrative Expense Load

The administrative expense load is a long-term estimate of administrative expenses, including selling expenses and general administrative expenses. This load does not vary by product or plan. These assumptions are based on the general ledger actual results for 2018 with known adjustments. Known adjustments include, but are not limited to, pay increases/raises for employees and administrative expenses as a result of Healthcare Reform and compliance requirements. The administrative expense allocation methodology used in pricing is appropriate because it is consistent with how UnitedHealthcare runs its business and how it allocates administrative costs for Statutory Filings and the Healthcare Reform Exhibits.

Profit and Risk Margin

The profit and risk margin is shown in Worksheet 2, Section III of the URRT. This target does not vary by product or plan.

The profit and risk margin is derived from the difference between the administrative expenses, taxes and fees, and 1 minus the target loss ratio.

The profit and risk margin results in an anticipated MLR that is above the minimum requirements as described in the Projected Loss Ratio section.

Taxes and Fees

Taxes and fees are expected to be 7.1% and include premium tax, exchange fees (if any), risk adjustment user fees, and federal income tax. The following is a breakdown of the taxes and fees.

Premium Taxes and Fees Allocation	Estimated % of Premium
Federal / State Income Tax on Profit & Risk Load	0.8%
Premium Tax	2.0%
ACA Taxes: Insurer Fee	2.7%
ACA Taxes: PCORI Fee	0.0%
ACA Taxes: Risk Adjustment User Fee	0.0%
ACA Taxes: Exchange User Fee	1.0%
All Other Taxes & Fees	0.6%
Total	7.1%

Marketplace user fees are applied as an adjustment to the Index Rate at the market level. The value reflects the expected mix of Marketplace and non-Marketplace enrollees.

Section 12: Calibration

Plan Adjusted Index Rates need to be calibrated to apply the allowable rating factors of age and geography in order to calculate the Consumer Adjusted Premium Rates. Calibration factors are applied uniformly to all plans.

Age Calibration

The calculated age curve calibration is 1.028, which equals one divided by the average age factor of the expected member distribution by age. The age factors used in this calculation are the DISB specified age curve.

Geographic Calibration

The geographic factor calibration is 1, which equals one divided by the expected average area factor. A table of the geographic rating factors is below.

Rating Area	Area Factor
1	1.000

Geographic rating factors are reviewed periodically versus UnitedHealthcare claims data that reflects unit cost differences by county. Such a review was conducted as part of our January 1, 2020 rate development.

Our analysis did not indicate that there were credible, material differences indicated by the comparison of currently approved area factors and the UHC data reflecting unit cost differences.

Population morbidity by area was not considered when determining geographic area factors.

Tobacco Calibration

Tobacco factors are not used in the rating of these products, and no calibration is needed.

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age and area.

Section 13: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is the final premium rate that is charged to an individual. It is developed by calibrating the plan adjusted index rate, and applying the consumer specific age and geographic rating factors. The calculation is provided below.

Plan Adjusted Index Rate

- x Age Calibration Factor
- x Geographic Calibration Factor
- x Consumer Specific Age Rating Factor
- x Consumer Specific Geographic Rating Factor
- x Small Group Trend Adjustment
- = Consumer Adjusted Premium Rate

Section 14: Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2020 is 86.2%. UnitedHealthcare Insurance Company agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

Since the last rate filing, UHC has elected to report a single quality improvement activity (QIA) amount of 0.8% of premium in lieu of actual QIA expenditures. This action is allowed per the 2019 Final Notice of Benefit and Payment Parameters (NBPP). Issuers electing to use the 0.8% must do it consistently across all states and markets subject to MLR, including amongst all affiliated issuers.

Section 15: AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. Additional details are provided below to describe the types of adjustments that were made for plan designs that are not directly compatible with the AV calculator.

Copays Paid in Conjunction with Coinsurance

Some of our plan designs include copays that are paid in conjunction with coinsurance in the coinsurance range. This benefit design is not directly compatible with the AV calculator, so the alternate methodology described in 45 CFR 156.135(b)(2) was used for the AV calculation. In order to modify the AV calculator input for a copay paid in conjunction with coinsurance, the following formula was used to estimate the insurer's cost share.

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) * (1-Member Coinsurance Rate)

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above. The copay was entered in the "Copay if separate" column.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. For example, if the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. All enrollees within a continuance table whose claims exceeded \$1,500 were included in the calculation of the average unit cost for each benefit type.

Benefits that Vary Based on Place of Service

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Tiered Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

Physician Tiering

Select plan designs include lower cost sharing when members utilize providers we designate as meeting cost and efficiency standards. The tiered network functionality of the AV calculator was utilized to account for the cost sharing differences. The utilization of providers was based on a UnitedHealthcare study of differences in cost sharing and their effectiveness at driving utilization patterns.

Per Occurrence Copays

Select plan designs have per occurrence copays where a copay is paid before coinsurance is applied between the deductible and maximum out of pocket. These copays accumulate to the maximum out of pocket. To reflect this type of benefit an effective insurer coinsurance rate was calculated based on the average unit cost of the service and member coinsurance rate. The calculation is as follows:

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) * (1-Member Coinsurance Rate)

Some of the copays only apply to portions of the benefit categories that the AV calculator defines. For example, the Inpatient Hospital Services includes both physician and facility charges. To the extent the plan design per occurrence copay only applies to a portion of the services, the tiered Network functionality was utilized. The mix of services within the AV calculator benefit categories was based on historical experience.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level where available.

Zero Dollar Copay for Dependents Under Age 19

Some plan designs assume no PCP copay applies for children under the age of 19. These copays were converted to an effective copay based on UnitedHealthcare historical membership distributions.

Laboratory and X-Ray Services

Some plan designs include a copay for minor lab and x-ray services. These copays are applied on a per visit basis. The AV Calculator assumes that the copays are on a per procedure basis. Therefore, the copay amounts are adjusted to reflect the equivalent per procedure amount.

Section 16: Membership Projections

The 2020 plan year membership projection was developed utilizing the experience period plan level membership distribution along with sales and persistency targets. Member distribution by plan was then based on current enrollment, taking into consideration changes in the portfolio of plans to be offered in 2020. Strictly for purposes of the URRT, we have projected membership by plan.

Section 17: Plan Type

A plan type of EPO & POS has been selected, which describes the plans exactly.

Section 18: Reliance

Due to responsibility allocation, I have relied upon other individuals within the UnitedHealthcare organization to provide certain assumptions. Although I have performed a limited review of the information and have not found it unreasonable or inconsistent, I have not reviewed it in enough detail to fully judge the reasonableness of the information due to the substantial amount of additional time required. I have therefore relied upon the expertise of those individuals who have developed the assumptions, and am providing the information required by Actuarial Standard of Practice 41, section 4.3. A list of reliances is included below.

<u>UnitedHealthcare Finance Department</u>

- Projected SG&A Assumption
- Total Projected Membership

<u>UnitedHealthcare National Pricing Team</u>

• Plan Relativity Modeling

UnitedHealthcare Healthcare Economics Department

- Projected Trend
- · Claims Reserves
 - ACO/Premium Designated Provider
- Cost Savings Estimates
- · Plan Relativity Modeling

Section 19: Actuarial Certification

I, Ryan Morgan, FSA, MAAA, am a Director, Actuarial Services for UnitedHealthcare, and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
 - In compliance with state and federal statutes and regulations related to the development of the index rate and allowable rating factors (such as 45 CFR 156.80 and 147.102).
 - Developed in compliance with the applicable Actuarial Standards of Practice.
 - Reasonable in relation to the benefits provided and population anticipated to be covered.
 - Neither excessive, deficient, nor unfairly discriminatory.
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CRF 156.80(d)(2) were used to generate plan level rates.
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I
 Unified Rate Review Template for all plans. Some of our plan designs are not directly compatible
 with the AV calculator. The values were developed in accordance with generally accepted
 actuarial principles and methodologies. The unique plan design actuarial certification required by
 45 CFR Part 156.135.
- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to
 develop their rates. Rather, it represents information required by federal regulation to be
 provided in support of the review of rate increases, for certification of qualified health plans for
 federally facilitated exchanges, and for certification that the index rate is developed in
 accordance with federal regulation and used consistently and only adjusted by the allowable
 modifiers.

Ryan Morgan	5/24/2019
Ryan Morgan, FSA, MAAA	Date
Director, Actuarial Services	

Actuarial Memorandum UnitedHealthcare Insurance Company, NAIC #79413 DC Small Group Rate Filing

May 24, 2019

This rate filing presents proposed premium rates effective January 1, 2020 through December 31, 2020 for medical and Rx benefit plans to be sold by the UnitedHealthcare Insurance Company to small group employers.

The filing has been prepared as required by the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", as well as current ACA rules and more recent guidance from the DC Department of Insurance. This rate filing should not be used for any other purposes. Within that context, there are no limitations or constraints on the use or applicability of the rating items discussed herein. The intended user of this filing is the DC Department of Insurance.

The benefit plans and rates are for non-grandfathered employers. The proposed rates and rate factors are in Exhibit 1, which also displays the metal level and actuarial value of each benefit plan. Benefit plan descriptions are in Exhibit 2. Exhibit 4 identifies new benefit plans being added in 2020, and 2019 benefit plans with plan changes (uniform modification).

Responding to the items in the DC Rate Filing Checklist:

1. Purpose of Filing. UnitedHealthcare is filing for the first time rates for 2020. The proposed 1st quarter 2020 rates are on average 12.3% higher than our 1st quarter 2019 rates. The rate changes vary by benefit plan as we have realigned our price relationships between plans. In addition, we are filing for quarterly rate increases as follows: 2Q19 + 2.0%, 3Q19 + 2.1%, 4Q19 + 2.0%. These quarterly rate increases are based on our trend rate of 8.3%. The average year-over-year renewal rate change is +11.2%, the minimum change on this entity is +5.9%, and the maximum change on this entity is +15.6%. Please see Exhibit 3 for detail on the rate changes.

2) Form Numbers. The form numbers are as follows: POL20.SHOP.I.2018.SG.DC, COC20.SHOP.I.2018.SG.DC, SBN20.CHP.I.2018.SG.DC.PL1, SBN20.CHP.I.2018.SG.DC.PL4, SBN20.CHP.I.2018.SG.DC.PL14, SBN20.CHP.I.2018.SG.DC.PL15, SBN20.CHP.I.2018.SG.DC.GO1, SBN20.CHP.I.2018.SG.DC.GO7, SBN20.CHP.I.2018.SG.DC.GO8, SBN20.CHP.I.2018.SG.DC.GO10, SBN20.CHP.I.2018.SG.DC.GO13, SBN20.CHP.I.2018.SG.DC.GO22, SBN20.CHP.I.2018.SG.DC.GO23, SBN20.CHP.I.2018.SG.DC.GO26, SBN20.CHP.I.2018.SG.DC.GO28, SBN20.CHP.I.2018.SG.DC.GO29, SBN20.CHP.I.2018.SG.DC.GO31, SBN20.CHP.I.2018.SG.DC.SL8, SBN20.CHP.I.2018.SG.DC.SL11, SBN20.CHP.I.2018.SG.DC.SL19, SBN20.CHC.I.2018.SG.DC.PL1, SBN20.CHC.I.2018.SG.DC.PL4, SBN20.CHC.I.2018.SG.DC.GO1, SBN20.CHC.I.2018.SG.DC.GO8, SBN20.CHC.I.2018.SG.DC.GO13, SBN20.CHC.I.2018.SG.DC.GO22, SBN20.CHC.I.2018.SG.DC.GO23, SBN20.CHC.I.2018.SG.DC.GO26, SBN20.CHC.I.2018.SG.DC.SL8, SBN20.CHC.I.2018.SG.DC.SL11, SBN20.CHC.I.2018.SG.DC.SL19, SBN20.CHC.I.2018.SG.DC.BR4, RID20.PDS.NET.I.2018.SG.DC, RID20.PDS.NET-OON.I.2018.SG.DC, RID20.PVCS.NET.I.2018.SG.DC, RID20.PVCS.NET-OON.I.2018.SG.DC, RID20.RX.NET.I.2018.SG.DC, RID20.RX.NET-OON.I.2018.SG.DC, SBN20.RX.NET.I.2018.SG.DC.20%, SBN20.RX.NET.I.2018.SG.DC.54075, SBN20.RX.NET.I.2018.SG.DC.104075, SBN20.RX.NET.I.2018.SG.DC.152550,

SBN20.RX.NET.I.2018.SG.DC.1050100150, SBN20.RX.NET.I.2018.SG.DC.NONE,

SBN20.RX.NET-OON.I.2018.SG.DC.20%, SBN20.RX.NET-OON.I.2018.SG.DC.54075, SBN20.RX.NET-OON.I.2018.SG.DC.104075, SBN20.RX.NET-OON.I.2018.SG.DC.152550, SBN20.RX.NET-OON.I.2018.SG.DC.1050100150, RID20.ODYSSEYTRAVEL.I.2018.SG.DC, RID20.REALAP.I.2018.SG.DC

- 3) HIOS Product ID. The HIOS product ID's for the respective products are as follows: CH+/Ins (POS): 41842DC001 and CH/Ins (EPO): 41842DC004
- 4) Effective Date. 1/1/2020.
- <u>5) Market</u>. The benefit plans will be offered in the small employer group market.
- 6) Status of Forms. The forms are open to new sales and are for non-grandfathered groups.
- 7) Benefits/Metal Levels. The benefits by plan are summarized in Exhibit 2. The metal level for each benefit plan is indicated in Exhibit 1.
- <u>7.1) AV Value</u>. The actuarial value for each plan design using the HHS provided AV calculator is indicated in Exhibit 1. For plan designs that do not fit into the AV calculator, certification of the methodology and input used is in Exhibit B.

8) Average Rate Increase Requested

Incremental:

1Q20/4Q19: +3.9% 2Q20/1Q20: +2.0% 3Q20/2Q20: +2.1% 4Q20/3Q20: +2.0%

Year-over-year renewal:

1Q20/1Q19: +12.3% 2Q20/2Q19: +11.7% 3Q20/3Q19: +11.1% 4Q20/4Q19: +10.4%

Average year-over-year renewal: +11.2%

9) Maximum Rate Increase Requested

Incremental:

1Q20/4Q19: +6.9% 2Q20/1Q20: +2.0% 3Q20/2Q20: +2.1% 4Q20/3Q20: +2.0%

Year-over-year renewal: +15.6%

10) Minimum Rate Increase Requested

Incremental:

1Q20/4Q19: -0.2% 2Q20/1Q20: +2.0% 3Q20/2Q20: +2.1% 4Q20/3Q20: +2.0%

Year-over-year renewal: +5.9%

- 11) Absolute Maximum Premium Increase. The absolute maximum year-over-year renewal increase, including one year of aging (20 to 21, which is an 11.1% increase in age factor), is +28.3%.
- 12) Average Renewal Rate Increase for a Year. The average renewal rate change by HIOS product ID is: 41842DC001 +11.4%, 41842DC004 +9.6%.

13) Rate Change History.

10/1/19: +2.7% 7/1/19: +2.6% 4/1/19: +2.6% 1/1/19: +1.1% 10/1/18: +1.7%

7/1/18: +1.8% 4/1/18: +1.7%

1/1/18: -3.0%

10/1/17: +2.6%

7/1/17: +2.5% 4/1/17: +2.5%

1/1/17: -5.7%

10/1/16: +1.9%

7/1/16: -3.2% 4/1/16: +1.9%

1/1/16: +5.0%

14) Exposure. As of February, 2019:

Policies: 1,674 Certificates: 7,013 Covered Lives: 11,950

- 15) Member Months. See Exhibit A.
- 16) Past Experience. See Exhibit A.
- 17) Index Rate. \$484.48

17.1) Rate Development.

The base experience is shown in Exhibit A.

We are proposing to set our 1st quarter 2020 on average 3.9% higher than our current 4th quarter 2019 rates, and then apply quarterly rate increases in each of the last three quarters of 2020. The quarterly rate increases are equivalent to an annual 8.3% trend. As shown in Exhibit D, our analysis indicates that these rates will yield a 79.5% underwriting loss ratio (claims divided by premium which includes PPACA fees).

The 2020 base rate of \$766.11 is calculated as follows: (2019 Base Rate) x (Trend with PPACA fees) x (Revenue Neutral Base Rate Adjustment) x (1/1/2020 Rate Change) 2020 Base Rate = (\$652.85) x (1.1072) x (1.028) x (1.031) = \$766.11

18) Credibility Assumption. We have set our rate levels based on the combined DC experience on our small group licenses, which we believe is credible.

- 19) Trend Assumption. See Exhibit T. At UnitedHealthcare, we have a team of actuaries whose responsibilities include developing forward-looking trend projections and monitoring historical performance in relation to trend. We rely on this team to provide guidance on trends appropriate for DC rate development.
- <u>20) Cost Sharing Changes</u> and <u>21) Benefit Changes</u>. Changes to member cost sharing were required for certain benefit plans. Use of the new federal Actuarial Value (AV) Calculator led to some benefit plans falling outside the allowed +2% /-4% AV metal ranges. Benefit plan changes were made to move these plans back into the allowed AV ranges. The benefit changes for these plans, and the estimated cost value of the changes, is shown in Exhibit 4.
- 22) Plan Relativities. We refined the medical plan price relativities to reflect the most recent methodology update using the most recent available models. The medical plan price relativities were developed using our pricing model ARC (Actuarial Relativity Calculator). The ARC model is based on UnitedHealthcare nationwide experience data, containing utilization frequencies and unit costs by service category, and claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan into ARC. The expected net-to-allowed relativity for each plan is then used to develop the plan relativities for each benefit plan. All benefit plans are priced consistently with each other, with the rates different only by the estimated value of the benefit differences. The prescription drug plan relativities were similarly developed using our ARC Pricing model: this model, based on nationwide UnitedHealthcare prescription drug experience, values the cost differences of Rx copays by tier, and other plan cost sharing features such as Rx deductibles and coinsurance.

Using the new ARC model (used for both medical and Rx price relativities), we set the new 2020Q1 base rates to be 2.8% higher, using our 2018 membership by benefit plan as weights, than the 2019Q1 rates. This is demonstrated in Exhibit 6.

- <u>23)</u> Rating Factors. We are resetting our 1st quarter 2020 Effective Date Adjustment (EDA) factors to 1.000. Rating factors are displayed on Exhibit 1. Exhibit 3 details the changes to rating factors.
- 23.1) Wellness Programs. No wellness programs are included in this rate filing.
- <u>24) Distribution of Rate Increases.</u> The distribution of rate increases is shown in the DISB Actuarial Memorandum Dataset.
- 25) Claim Reserve Needs. The incurred period used for the base period is 1/1/18 through 12/31/18, using claims paid through 2/28/19. The claim reserve amounts are included in Exhibit A. A description of our reserving methodology is included in the Part III Actuarial Memorandum.
- 26) Administrative Costs of Programs that Improve Health Care Quality. The Improving Health Care Quality costs in total for our small group licenses is 0.8% of premium.
- <u>27) Taxes and Licensing or Regulatory Fees</u>. The amount of taxes, licenses, and fees subtracted from premium in the denominator of the medical loss ratio calculation is 7.2%. Differences from amounts in the Supplemental Health Care Exhibit are due to different amounts of PPACA fees by year, and different Federal Income Taxes due to different underwriting loss ratios.

- 28) Medical Loss Ratio (MLR). The anticipated Federal MLR is 86.2%, which is greater than the 80% minimum. The estimated Federal MLR components, adjustments, and formula are as follows:
 - 79.5% Underwriting loss ratio
 - 0.8% QI/HIT Medical costs added
 - 7.1% Taxes, regulatory fees and assessments

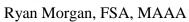
MLR formula: $[(UW LR) \times (1 + QIT)]/(1 - taxes)$

- <u>29) Risk Adjustment</u>. Based on analysis done in conjunction with a national actuarial consulting firm, we estimate we will be a 2.7% risk payer in total for our small group licenses, this is assumed in the underwriting loss ratio development.
- 30) Past and Prospective Loss Experience Within and Outside the State. Only loss experience on DC plans, written on DC employers, was used in the development of the rates. This experience does include medical services provided outside DC, to employees of DC employers who live outside DC, or to DC residents who obtain medical services outside DC. We have set our rate levels based on the total overall experience of our small group licenses in DC, which we believe is credible, thus not requiring use of loss experience outside the state.
- 31) A Reasonable Margin for Reserve Needs. The profit margin assumed in the development of the proposed rates is 3.0% of premium. This assumption was derived as: 100% projected underwriting loss ratio projected expenses (including PPACA fees) as % of premium projected taxes (including FIT) as % of premium. This methodology has not changed from prior filings.
- 32) Past and Prospective Expenses. The expenses assumed in the development of the proposed rates are as follows. These are the total average expenses for the small group licenses. Except for difference in PPACA fees which vary by calendar year, they are forecasted 2020 year expenses that are expected to continue in the future.

% of Premium	Expense Category
2.9%	Salaries, wages, employment taxes, and other employee benefits
2.6%	Commissions
7.1%	Taxes, licenses, and other regulatory fees
1.6%	Cost containment programs / quality improvement activities
3.4%	All other administrative expenses
17.5%	Total

- 33) Any Other Relevant Factors Within and Outside the State. None.
- 34) Other. None.
- 35) Actuarial Certification.
- I, Ryan Morgan, a Director at UnitedHealthcare, am an FSA and MAAA. I satisfy the 2018 continuing professional development requirements of the Academy and therefore am qualified to issue this 2019 statement of actuarial opinion. I have reviewed applicable ASOPs during the preparation of this rate filing. There are no known cautions with regard to risk or uncertainty in the items discussed in this rate filing. There are no conflicts of interest with regards to my production of this rate filing.

I certify that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of DC and all applicable Actuarial Standards of Practice, including ASOP No. 8, and the rates are not unfairly discriminatory.



Myan Morgan

Date: 5/24/2019

- 36) Part I Preliminary Justification for Grandfathered Plan Filings. Not applicable.
- <u>36.1) Unified Rate Review Template</u>. This is provided via SERFF.
- 37) Part II Preliminary Justification. This is provided via SERFF.
- 38) DISB Actuarial Memorandum Dataset. This is provided via SERFF.
- 39) DC Plain Language Summary. This is provided via SERFF.
- 40) Summary of Components for Requested Rate Change: Please see Exhibit 3.
- 41) CCIIO Risk Adjustment Transfer Elements Extract (RATE 'E'): This was provided via SERFF.
- 42) Additional Requirements for Stand-Alone Dental Plans. Not applicable.

<u>List of exhibits included in rate filing</u>:

Exhibit 1: Rates and rate factors.

Exhibit 2: Benefit plan descriptions.

Exhibit 3: Rate factor changes.

Exhibit 4: Rating example.

Exhibit A: Member months, earned premium & incurred claim experience.

Exhibit B: Certification for AV calculator.

Exhibit C: PPACA fees & development of fee EDA factors by quarter.

Exhibit D: Development of underwriting loss ratio.

Exhibit T: Trend assumptions and development.

Please keep these rates confidential to the extent allowed by DC law.

If you have questions, or need any further information, please do not hesitate to contact me.

Sincerely,

Ryan Morgan, FSA, MAAA Director, Actuarial Services

Myan Morgan

UnitedHealthcare

Federal Rate Filing Justification Part III Actuarial Memorandum and Certification

UnitedHealthcare Insurance Company

NAIC: 0707-41842

FEIN: 362739571

State of District of Columbia Rate Review

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Section 1: Purpose

The following is a rate filing prepared by UnitedHealthcare Insurance Company. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services and the state of District of Columbia. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template (URRT).

This filing establishes rates intended to be used for non-grandfathered PPACA compliant small group health benefit plans sold on the Small Business Health Options Program in District of Columbia for the 2020 plan year. A rate increase is being filed at this time. The rates and other information in this submission are based on the current regulations and guidance from HHS. Changes to this filing may be necessary if there are revisions to the regulations or updated guidance from HHS.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the District of Columbia Department of Insurance and Financial Services. It will demonstrate compliance with state and federal laws and regulations related to the development of the index rate and allowable rating factors and is not intended to be used for any other purpose.

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by D.C. Code section 31-3303.08(b) and D.C. Code section 2-534(a)(1). If the prohibition against disclosure by the Department of Insurance and Financial Services is reassessed at a later date, it may not be disclosed to any other state or federal regulatory agencies unless the recipient agrees in writing prior to receipt to maintain the confidentiality of the information.

Section 2: General Information

Company Identifying Information

Company Legal Name: UnitedHealthcare Insurance Company

State: District of Columbia

HIOS Issuer ID: 41842

Market: Small Business, 1-50
Proposed Effective Date: January 01,2020

Primary Contact Information

Name: Ryan Morgan, FSA, MAAA

Telephone Number: 414-443-4287

Email Address: ryan_morgan2@uhc.com

Section 3: Proposed Rate Changes

The proposed change in rates for this filing is 11.24% compared to the prior filing. These changes are applied uniformly to all plans within a rating area. The proposed pricing trend is 8.29% annually.

The primary drivers of the proposed rate changes are the following:

- Changes in medical service costs
 - Increasing Cost of Medical Services Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
 - Increased Utilization The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
 - O Higher Costs from Deductible Leveraging Health care costs continue to rise every year. If deductibles and copayments remain the same, a greater percentage of health care costs need to be covered by health insurance premiums each year.
 - Cost shifting from the public to the private sector Reimbursements from the Center for Medicare
 and Medicaid Services (CMS) to hospitals do not generally cover all of the cost of care. The cost
 difference is being shifted to private health plans. Hospitals typically make up this difference by
 charging private health plans more.
 - Impact of New Technology Improvements to medical technology and clinical practice often result in the use of more expensive services - leading to increased health care spending and utilization.
- Administrative costs and anticipated profit
 - UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.
 - Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.
 - State and/or Federal government imposed taxation and fees are additional significant factors that impact health care spending. These fees include ACA taxes and fees which will have increased health insurance costs and need to be reflected in premium.
- Changes that vary by plan
 - All plan relativity factors have been updated to reflect UnitedHealthcare's most recent pricing model.
 - The impact of any changes to plans that have occurred due to uniform modification are also reflected in the updated plan relativity factors. Please see the "Plan Adjusted Index Rate" section of the memorandum for more detail on these changes.

We refined the medical and pharmacy plan price relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing by the estimated value of the benefits and the expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status. The net impact of all changes by plan can be found in Worksheet 2, Section I of the Unified Rate Review Template.

Significant factors driving the proposed rate changes are discussed in further detail in Section 6 (*Projection Factors*) and Section 7 (*Credibility Manual Rate Development*) of this memorandum.

Section 4: Experience and Current Period Premium, Claims and Enrollment

Paid Through Date

The experience period is 1/1/2018 through 12/31/2018, with claims paid through 2/28/2019.

Current Date

The current enrollment and premium is reported as of 12/31/2018.

Support for estimate of incurred but not paid claims

Historical claims are categorized both by the month in which they were incurred and the month in which they were adjudicated. For incurral months with sufficient adjudicated claim experience, incurred claims are estimated by applying completion factors derived from the historical claims. Adjustments are made based on specific knowledge of the entity (e.g., catastrophic claims, pended claims, etc.). For incurral months where adjudicated claim experience is not sufficient to rely on completion factors, a PMPM is used to estimate incurred claims. PMPM estimates are based on expected claim seasonality patterns, monthly calendar days and work days, emerging claim trends, and other factors.

The same completion factors are applied to both incurred and allowed claims amounts.

Experience Period Risk Adjustment

Risk Adjustments for the experience period are not known at this time.

Our 2018 risk adjustment transfer PMPM is estimated using data provided to UnitedHealthcare as a result of our participation in a multi-state study done by a large, independent actuarial consulting firm. Based on the results of that study, we expect that risk level of the membership insured by UnitedHealthcare Insurance Company to be lower than the market. This results in an approximate adjustment of \$5.66 PMPM.

Experience Period Index Rates

Experience Period Index Rates are defined as the allowed claims PMPM for Essential Health Benefits during the Experience Period. With the introduction of the URRT 5.0 and the breakout of service level EHB claims, the information provided reflects a reasonable estimate of the EHBs.

Section 5: Benefit Categories

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered. The benefit categories were defined by our claims department using standard industry definitions.

Inpatient Hospital

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital

Includes non-capitated facility services for surgical, emergency room, laboratory, radiology, therapeutic, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional

Includes non-capitated primary care, specialist care, therapeutic, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical

Includes non-capitated ambulatory, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other services.

Capitation

Includes all services provided under one or more capitated agreements.

Prescription Drug

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

Section 6: Projection Factors

Trend

Two years of annual trend were applied to our 2018 experience to project it to the 2020 rating period. Our most recent analysis indicates annual trend in the state of District of Columbia for the 2019 and 2020 calendar years will be 8.1% and 8.3%, respectively. The table below details the components of each trend factor.

Trend Component	2019	2020
Unit Cost	3.90%	4.10%
Utilization	3.30%	3.30%
Total	8.10%	8.30%

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected. Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macroeconomic data is often used to develop assumptions regarding directional changes in national health care consumption rates. UnitedHealthcare uses same store analysis to reflect utilization.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence the mix of procedures. Unit cost is based on our contractual changes with providers.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Section 7: Credibility Manual Rate Development

Adjustments Made to the Data

Adjustments similar to the ones described in Section 6 were applied to the experience of the credibility manual to project it to the projection period. In addition, the credibility manual was adjusted to reflect the average age, geography, plan design and morbidity of the adjusted experience period claims.

Inclusion of Capitation Payments

Capitation payments are included in both the experience and projections.

Section 8: Credibility of Experience

The experience for this legal entity contains 127,463 member months which does not exceed the 360,000 member months needed to be considered fully credible. As such the credibility of UnitedHealthcare Insurance Company is set to 0%, and the remaining uses the credibility manual described above.

Consideration was given to ASOP #25 when determining the credibility and appropriateness of the experience and the manual rate. The manual rate is sufficiently independent from the experience and can be blended with it for purposes of rate development.

Section 9: Development of Projected Index Rate

The experience period index rate is \$408.45 PMPM.

The Index Rate For the experience period is approximately 98.52% of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly. The Index Rate in the projection period represents 98.52% of allowed claims due to the benefits in excess of EHBs.

The projected index rate of \$484.48 was calculated by trending and adjusting the experience period index rate to the projection period, including blending the experience with a manual rate if the experience was not fully credible. It is established in accordance with the requirements of 45 CFR §156.80(d). See sections 6, 7, and 8 of this memo for more details.

Section 10: Development of the Market-wide Index Rate

Reinsurance

There is no reinsurance program in force for this business, and as a result there are no reinsurance recoveries to report.

Risk Adjustment Payment/Charge

UnitedHealthcare Insurance Company anticipates paying for risk adjustment transfers in the state of District of Columbia for the 2020 plan year, which has been grossed up to \$13.03 PMPM on an allowed basis for purposes of calculating the Market-wide Adjusted Index Rate. We are assuming the risk level of our business relative to that of our competitors for the 2020 plan year will be similar to what it was in the 2018 plan year. Since risk adjustment transfer payments are a function of the market level premium, our 2020 risk adjustment transfer PMPM amount is calculated by adjusting our estimated 2018 risk adjustment transfer PMPM amount for the projected market level trend, changes in reinsurance fees and recoveries, and other adjustments based on the overall financial performance of the market.

Exchange User Fees

Marketplace user fees are applied as an adjustment to the Index Rate at the market level. The value reflects the expected mix of Marketplace and non-Marketplace enrollees.

The market adjusted index rate includes market-wide adjustments for reinsurance, risk adjustment transfers and exchange user fees (if any).

	Net Federal or	Risk Adjustment	Exchange Fee	
Index Rate	State Reinsurance	Payment/Charge	Adjustment	Market Adjusted
	(allowed basis)	(allowed basis)	(allowed basis)	Index Rate
\$484.48	\$0.00	(\$13.03)	0.00%	\$497.51

The figures above may not tally exactly due to rounding of the display.

Section 11: Plan Adjusted Index Rate

Actuarial Value and Cost Sharing Adjustment

UnitedHealthcare has a proprietary pricing model that was used in developing the actuarial value and cost sharing adjustment for each plan. The model calculates plan relativity factors for medical and pharmacy benefits. Also included under the actuarial value and cost sharing adjustment are adjustments for leveraging and the difference between the average plan relativity factor and the projected paid to allowed ratio.

UnitedHealthcare Insurance Company does not utilize Induced Demand factors in our rate development. Instead, our plan-specific pricing factors are based on an analysis of UnitedHealthcare Insurance Company's nationwide block of Small Group health insurance, which reflects over 10 million member months of experience. Our approach complies with the prohibition of rating for morbidity differences by normalizing out the cost differences attributable to morbidity as measured by HHS's risk adjustment mechanism.

Historical UnitedHealthcare experience was used to develop the actuarial value and cost sharing adjustment.

Provider network, delivery system and utilization management adjustment

Any adjustments for these items are included in the plan relativity factors.

Distribution and Administrative Costs

Distribution and administrative costs include premium tax, risk adjustment user fees, SG&A, quality improvements, federal income tax, and after-tax income. Risk adjustment transfers, net reinsurance recoveries and exchange fees are excluded because they are accounted for in the market adjusted index rate.

Administrative Expense Load

The administrative expense load is a long-term estimate of administrative expenses, including selling expenses and general administrative expenses. This load does not vary by product or plan. These assumptions are based on the general ledger actual results for 2018 with known adjustments. Known adjustments include, but are not limited to, pay increases/raises for employees and administrative expenses as a result of Healthcare Reform and compliance requirements. The administrative expense allocation methodology used in pricing is appropriate because it is consistent with how UnitedHealthcare runs its business and how it allocates administrative costs for Statutory Filings and the Healthcare Reform Exhibits.

Profit and Risk Margin

The profit and risk margin is shown in Worksheet 2, Section III of the URRT. This target does not vary by product or plan.

The profit and risk margin is derived from the difference between the administrative expenses, taxes and fees, and 1 minus the target loss ratio.

The profit and risk margin results in an anticipated MLR that is above the minimum requirements as described in the Projected Loss Ratio section.

Taxes and Fees

Taxes and fees are expected to be 7.1% and include premium tax, exchange fees (if any), risk adjustment user fees, and federal income tax. The following is a breakdown of the taxes and fees.

Premium Taxes and Fees Allocation	Estimated % of Premium
Federal / State Income Tax on Profit & Risk Load	0.8%
Premium Tax	2.0%
ACA Taxes: Insurer Fee	2.7%
ACA Taxes: PCORI Fee	0.0%
ACA Taxes: Risk Adjustment User Fee	0.0%
ACA Taxes: Exchange User Fee	1.0%
All Other Taxes & Fees	0.6%
Total	7.1%

Marketplace user fees are applied as an adjustment to the Index Rate at the market level. The value reflects the expected mix of Marketplace and non-Marketplace enrollees.

Section 12: Calibration

Plan Adjusted Index Rates need to be calibrated to apply the allowable rating factors of age and geography in order to calculate the Consumer Adjusted Premium Rates. Calibration factors are applied uniformly to all plans.

Age Calibration

The calculated age curve calibration is 1.028, which equals one divided by the average age factor of the expected member distribution by age. The age factors used in this calculation are the DISB specified age curve.

Geographic Calibration

The geographic factor calibration is 1, which equals one divided by the expected average area factor. A table of the geographic rating factors is below.

Rating Area	Area Factor
1	1.000

Geographic rating factors are reviewed periodically versus UnitedHealthcare claims data that reflects unit cost differences by county. Such a review was conducted as part of our January 1, 2020 rate development.

Our analysis did not indicate that there were credible, material differences indicated by the comparison of currently approved area factors and the UHC data reflecting unit cost differences.

Population morbidity by area was not considered when determining geographic area factors.

Tobacco Calibration

Tobacco factors are not used in the rating of these products, and no calibration is needed.

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age and area.

Section 13: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is the final premium rate that is charged to an individual. It is developed by calibrating the plan adjusted index rate, and applying the consumer specific age and geographic rating factors. The calculation is provided below.

Plan Adjusted Index Rate

- x Age Calibration Factor
- x Geographic Calibration Factor
- x Consumer Specific Age Rating Factor
- x Consumer Specific Geographic Rating Factor
- x Small Group Trend Adjustment
- = Consumer Adjusted Premium Rate

Section 14: Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2020 is 86.2%. UnitedHealthcare Insurance Company agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

Since the last rate filing, UHC has elected to report a single quality improvement activity (QIA) amount of 0.8% of premium in lieu of actual QIA expenditures. This action is allowed per the 2019 Final Notice of Benefit and Payment Parameters (NBPP). Issuers electing to use the 0.8% must do it consistently across all states and markets subject to MLR, including amongst all affiliated issuers.

Section 15: AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. Additional details are provided below to describe the types of adjustments that were made for plan designs that are not directly compatible with the AV calculator.

Copays Paid in Conjunction with Coinsurance

Some of our plan designs include copays that are paid in conjunction with coinsurance in the coinsurance range. This benefit design is not directly compatible with the AV calculator, so the alternate methodology described in 45 CFR 156.135(b)(2) was used for the AV calculation. In order to modify the AV calculator input for a copay paid in conjunction with coinsurance, the following formula was used to estimate the insurer's cost share.

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) * (1-Member Coinsurance Rate)

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above. The copay was entered in the "Copay if separate" column.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. For example, if the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. All enrollees within a continuance table whose claims exceeded \$1,500 were included in the calculation of the average unit cost for each benefit type.

Benefits that Vary Based on Place of Service

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Tiered Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

Physician Tiering

Select plan designs include lower cost sharing when members utilize providers we designate as meeting cost and efficiency standards. The tiered network functionality of the AV calculator was utilized to account for the cost sharing differences. The utilization of providers was based on a UnitedHealthcare study of differences in cost sharing and their effectiveness at driving utilization patterns.

Per Occurrence Copays

Select plan designs have per occurrence copays where a copay is paid before coinsurance is applied between the deductible and maximum out of pocket. These copays accumulate to the maximum out of pocket. To reflect this type of benefit an effective insurer coinsurance rate was calculated based on the average unit cost of the service and member coinsurance rate. The calculation is as follows:

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) * (1-Member Coinsurance Rate)

Some of the copays only apply to portions of the benefit categories that the AV calculator defines. For example, the Inpatient Hospital Services includes both physician and facility charges. To the extent the plan design per occurrence copay only applies to a portion of the services, the tiered Network functionality was utilized. The mix of services within the AV calculator benefit categories was based on historical experience.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level where available.

Zero Dollar Copay for Dependents Under Age 19

Some plan designs assume no PCP copay applies for children under the age of 19. These copays were converted to an effective copay based on UnitedHealthcare historical membership distributions.

Laboratory and X-Ray Services

Some plan designs include a copay for minor lab and x-ray services. These copays are applied on a per visit basis. The AV Calculator assumes that the copays are on a per procedure basis. Therefore, the copay amounts are adjusted to reflect the equivalent per procedure amount.

Section 16: Membership Projections

The 2020 plan year membership projection was developed utilizing the experience period plan level membership distribution along with sales and persistency targets. Member distribution by plan was then based on current enrollment, taking into consideration changes in the portfolio of plans to be offered in 2020. Strictly for purposes of the URRT, we have projected membership by plan.

Section 17: Plan Type

A plan type of EPO & POS has been selected, which describes the plans exactly.

Section 18: Reliance

Due to responsibility allocation, I have relied upon other individuals within the UnitedHealthcare organization to provide certain assumptions. Although I have performed a limited review of the information and have not found it unreasonable or inconsistent, I have not reviewed it in enough detail to fully judge the reasonableness of the information due to the substantial amount of additional time required. I have therefore relied upon the expertise of those individuals who have developed the assumptions, and am providing the information required by Actuarial Standard of Practice 41, section 4.3. A list of reliances is included below.

<u>UnitedHealthcare Finance Department</u>

- Projected SG&A Assumption
- Total Projected Membership

<u>UnitedHealthcare National Pricing Team</u>

• Plan Relativity Modeling

UnitedHealthcare Healthcare Economics Department

- Projected Trend
- Claims Reserves
 - ACO/Premium Designated Provider
- Cost Savings Estimates
- Plan Relativity Modeling

Section 19: Actuarial Certification

I, Ryan Morgan, FSA, MAAA, am a Director, Actuarial Services for UnitedHealthcare, and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
 - In compliance with state and federal statutes and regulations related to the development of the index rate and allowable rating factors (such as 45 CFR 156.80 and 147.102).
 - Developed in compliance with the applicable Actuarial Standards of Practice.
 - Reasonable in relation to the benefits provided and population anticipated to be covered.
 - Neither excessive, deficient, nor unfairly discriminatory.
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CRF 156.80(d)(2) were used to generate plan level rates.
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I
 Unified Rate Review Template for all plans. Some of our plan designs are not directly compatible
 with the AV calculator. The values were developed in accordance with generally accepted
 actuarial principles and methodologies. The unique plan design actuarial certification required by
 45 CFR Part 156.135.
- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to
 develop their rates. Rather, it represents information required by federal regulation to be
 provided in support of the review of rate increases, for certification of qualified health plans for
 federally facilitated exchanges, and for certification that the index rate is developed in
 accordance with federal regulation and used consistently and only adjusted by the allowable
 modifiers.

Ryan Morgan	5/24/2019
Ryan Morgan, FSA, MAAA	Date
Director, Actuarial Services	



10701 West Research Drive, WI030-1000 Wauwatosa, WI 53226 Phone 414-443-4287

E-Mail: ryan_morgan2@uhc.com

May 24, 2019

Efren Tanhehco, Actuary
DC Department of Insurance Securities & Banking
810 First Street, NE Suite 701
Washington, DC 20002

Re: UnitedHealthcare Insurance Company

Small Group Rate Filing

Dear Mr. Tanhehco:

This rate filing presents proposed premium rates effective January 1, 2020 through December 31, 2020 for medical and Rx benefit plans to be sold by the UnitedHealthcare Insurance Company to small group employers. The benefit plans and rates are for non-grandfathered employers.

A. Company Name: UnitedHealthcare Insurance Company

B. NAIC Company Code: 79413

C. SERFF Tracking #: UHLC-131909980

D. Date Filing Submitted: 05/24/2019

E. Proposed Effective Date: 1/1/2020

F. Type of Product: Medical and prescription drug insurance, offered both in-network only and innetwork with out-of-network benefits.

G. Market: Small group, employers with 50 or fewer eligible employees.

H. Scope and Purpose of Filing: 2020 rates for small group plans meeting the requirements of the Patient Protection and Affordable Care Act (PPACA).

I. Initial Filing or Rate Change: Initial filing for 2020, rate change to previously filed and approved 2019 rates.

J. Rates apply to existing DC policyholders.

K. Overall Premium Impact of Filing on DC Policyholders: An average 11.2% renewal rate increase.

L. Contact Information: Ryan Morgan, 414-443-4287; Email: ryan_morgan2@uhc.com.

If you have any questions, please do not hesitate to reach out.

Sincerely,

Ryan Morgan, FSA, MAAA Director, Actuarial Services

Kyan Morgan

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1	Unified Rate Review v5.0									To add a p	product to Wor	sheet 2 - Plan I	Product Info, sel	ect the Add Prod	luct butte
2										To add a p	olan to Worksh	et 2 - Plan Prod	duct Info, select	the Add Plan but	tton or C
3	Company Legal Name:	UnitedHealthcare Insurance Con	npany					State:	DC	To validat	e. select the Va	lidate button o	r Ctrl + Shift + I.		
4		41842						Market:	Small Group		, select the Fin				
+								iviai ket.	Siliali Group	10 Jinuiize	, select the rin	ilize button or c	LII + SIIIJ L + F.		
5	Effective Date of Rate Change(s):	1/1/2020													
6															
7															
8	Market Level Calculations (Same for all	l Plans)													
)															
0															
1	Section I: Experience Period Data	_													
2	Experience Period:		1/1/2018	to	12/31/2018										
.3				<u>Total</u>	PMPM										
.4	Allowed Claims			\$52,843,233.22	\$414.58										
.5	Reinsurance			\$0.00	\$0.00										
6	Incurred Claims in Experience Period			\$45,608,198.86	\$357.82										
.7	Risk Adjustment			-\$721,535.60	-\$5.66										
18	Experience Period Premium			\$56,158,345.45	\$440.59										
9	Experience Period Member Months			127,463											
0															
21	Section II: Projections														
22		Samuel and Barded Indian	Year 1	Trend	Year 2	Trend	Total de de Sup Allenna de Claire								
	S 51 6 . 1	Experience Period Index Rate PMPM	Cost	Utilization	Cost	Utilization	Trended EHB Allowed Claims PMPM								
.3	Benefit Category	Rate PIVIPIVI	COST												
		674.74	4.020	4.022											
-	Inpatient Hospital	\$71.74	1.039	1.032	1.043	1.037	\$83.20								
25	Outpatient Hospital	\$119.64	1.039	1.032	1.043 1.043	1.037 1.037	\$83.20 \$138.75								
25	Outpatient Hospital Professional	\$119.64 \$116.64	1.039 1.039	1.032 1.032	1.043 1.043 1.043	1.037 1.037 1.037	\$83.20 \$138.75 \$135.27								
25	Outpatient Hospital Professional Other Medical	\$119.64 \$116.64 \$3.08	1.039 1.039 1.039	1.032 1.032 1.032	1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57								
5 16 17	Outpatient Hospital Professional Other Medical Capitation	\$119.64 \$116.64 \$3.08 \$13.95	1.039 1.039 1.039 1.039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18								
15 16 17 18	Outpatient Hospital Professional Other Medical Capitation Prescription Drug	\$119.64 \$116.64 \$3.08 \$13.95 \$83.40	1.039 1.039 1.039	1.032 1.032 1.032	1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18	Outpatient Hospital Professional Other Medical Capitation	\$119.64 \$116.64 \$3.08 \$13.95	1.039 1.039 1.039 1.039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18								
15 16 17 18 19	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total	\$119.64 \$116.64 \$3.08 \$13.95 \$83.40	1.039 1.039 1.039 1.039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
5 6 7 8 9 9 10 11	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment	\$119.64 \$116.64 \$3.08 \$13.95 \$83.40	1.039 1.039 1.039 1.039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 19 10 11 12	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift	\$119.64 \$116.64 \$3.08 \$13.95 \$83.40	1.039 1.039 1.039 1.039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 19 10 11 13 14	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes	\$119.64 \$116.64 \$3.08 \$13.95 \$83.40	1.039 1.039 1.039 1.039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 15 16 17 18 18 19 10 11 13 14 15 16	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 18 19 10 11 11 15 16 17	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1.039 1.039 1.039 1.039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 19 19 10 11 11 15 16 17	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
5 6 7 8 9 0 1 2 3 4 5 6 7	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000 1.000 1.042 \$498.03	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
5 6 7 8 9 0 1 2 3 4 5 6 7 8	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000 1.009 1.042 \$498.03	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
5 6 7 8 9 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000 1.009 1.042 \$498.03	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 18 19 10 11 11 12 13 14 14 15 16 17 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000 1.009 1.042 \$498.03	1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 18 19 10 11 11 11 12 13	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility %	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000 1.009 1.042 \$498.03	1.037 1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility % Projected Index Rate for	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000 1.009 1.042 \$498.03 \$484.48 0.00%	1.037 1.037 1.037 1.037 1.037 1.037 1.037 Projected Period Totals \$51,753,274,24 \$50,00 -\$5,66,842,89	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 18 19 19 10 11 11 12 13 14 14 15	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility % Projected Index Rate for Reinsurance Risk Adjustment Payment/Charge Exchange User Fees	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.000	1.037 1.037 1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 18 19 10 11 12 13 14 14 15 16	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility %	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.000 1.000 1.000 1.009 1.042 \$498.03 \$484.48 0.00%	1.037 1.037 1.037 1.037 1.037 1.037 1.037 Projected Period Totals \$51,753,274,24 \$50,00 -\$5,66,842,89	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 18 19 10 11 11 12 13 14 14 15 16 17	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility % Projected Index Rate for Reinsurance Risk Adjustment Payment/Charge Exchange User Fees Market Adjusted Index Rate	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.000	1.037 1.037 1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
5 6 7 8 9 10 11 12 13 14 15 16 17 18 18	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility % Projected Index Rate for Reinsurance Risk Adjustment Payment/Charge Exchange User Fees	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.000	1.037 1.037 1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
15 16 17 18 19 10 11 11 15 16 16 17 18 19 19 19 19 19 19 19 19 19 19 19 19 19	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility % Projected Index Rate for Reinsurance Risk Adjustment Payment/Charge Exchange User Fees Market Adjusted Index Rate	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.000	1.037 1.037 1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
5 6 7 8 9 0 1 2 3 4 4 5 6 7 8 9 0 1 1 2 3 4 4 5 6 7 7 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility % Projected Index Rate for Reinsurance Risk Adjustment Payment/Charge Exchange User Fees Market Adjusted Index Rate	\$119.64 \$116.64 \$3.08 \$13.95 \$83.90 \$408.45	1039 1039 1039 1039 1039 1039	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.000	1.037 1.037 1.037 1.037 1.037 1.037 1.037	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72								
5 6 7 8 9 0 1 2 3 4 4 5 6 7 8 9 0 1 1 2 3 4 4 5 7 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Outpatient Hospital Professional Other Medical Capitation Prescription Drug Total Morbidity Adjustment Demographic Shift Plan Design Changes Other Adjusted Trended EHB Allowed Claims P Manual EHB Allowed Claims PMPM Applied Credibility % Projected Index Rate for Reinsurance Risk Adjustment Payment/Charge Exchange User Fees Market Adjusted Index Rate	\$119.64 \$116.64 \$3.08 \$13.95 \$83.40 \$408.45	1/1/2020	1.032 1.032 1.032 1.032	1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.043 1.040 1.000 1.000 1.000 1.000 1.000 1.042 \$498.03 \$484.48 \$5.0.00 -\$13.03 0.00% \$497.51	1.037 1.037 1.037 1.037 1.037 1.037 1.037 1.037 Projected Period Totals \$61,753,274.24 \$0.00 \$-\$1,660,842.89 \$0.00 \$63,414,117.13	\$83.20 \$138.75 \$135.27 \$3.57 \$16.18 \$96.72 \$473.69	to persons	not authorized t	o receive the in	formation. Un	authorized disc	losure may resu	It in prosecution	ı to the

rksheet 2 - Plan Product Info, select the Add Product button or Ctrl + neet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift +

Company Legal Name:	UnitedHealthcare Insurance Company	To add a plan to the Worksheet 2 - Plan Product infty, select the Add Plan button or Chri + Shift + L. State: DC To voidable, select the Voidable button or Chri + Shift + L.	
HIOS Issuer ID: Effective Date of Rate Change(s):	41962 1/1/2009	Market: Small Group To finalise, select the Finalise button or Corl + Shift + F.	
Effective Date of Rate Change(s): Product/Plan Level Calculations	1/1/1000		
Field # Section t General Product and Plan Information 1.1 Product Name	05	DC001 Plans	CCOOP Plans
12 Product ID		4184200001	418/GDC004
1.3 Plan Name	Terminated Profess Structure Structu	enas sous succi sous sous sous sous sous sous sous sou	90.83 90.80 90.85 80.87 80.87 90.89 80.47 90.88 80.87 90.81 80.87 80.87
1.4 Plan ID (Standard Component ID)	418420C001000 418420C0010006 418420C0010004 418420C001007 418420C001000 418420C001002 418420C001002 418420C001002 418420C001004 418420C00004 418420C001004 418420C000004 418420C000004 418420C000004 418420C0000004 418420C0000004 418420C0000004 418420C00000	1005 4184DC001007 4184DC002008	4184070000001 418430700000000000000000000000000000000000
1.5 Metal 1.6 AV Metal Value	Not Applicable Platinum Platinum Platinum Platinum Gold Gold Gold G 0.000 0.000 0.007 0.007 0.002 0.001 0.004 0.012 0.015 0.0	Gold Gold Gold Gold Gold Gold Gold Gold	Patinum Futinum Gold Gold Gold Gold Gold Gold Gold Gold
1.7 Plan Category	Terminated Recognice Recognice Recognice Recognice Recognice Recognice Recognice	regine Recognice Recognice Recognice Recognice New New New Recognice Recognice New Territories	Recognize
1.9 PlanType 1.9 Exchange Plan?	POS POS POS POS POS POS POS POS	POS	04 04 04 04 04 04 04 04 04 04 04 04 04
1.10 Effective Date of Proposed Rates	1/1/2002 1/1/2002 1/1/2002 1/1/2002 1/1/2002 1/1/2002 1/1/2002 1/1/2002 1/1/2002 1/1/2002	GSSS 1/1/2009 1/1/2009 1/1/2009 1/1/2009 1/1/2009 1/1/2009 1/1/2009 1/1/2009 1/1/2009 1/1/2009 1/1/2009	1/1/2009 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020 1/1/2020
1.11 Cumulative Rate Change % (over 12 mos prior) 1.12 Product Rate increase %	0.00% 13.40% 14.20% 14.50% 0.00% 8.50% 8.30% 8.20% 10.1	5.00% \$1,70% \$0.70% \$7.70% \$9.00% 0.00% 0.00% 0.00% 6.90% 9.00% 0.00% 0.00%	12.40N 14.20N 8.10N 11.70N 10.60N 9.60N 8.70N 10.00N 6.80N 0.00N 8.90N 11.00N 0.00N
1.12 Submission Level Rate Increase %		11-975	9.6/5
Worksheet 1 Totals Section 8: Experience Period and Current Plan Le	to distance for		
2.1 Plan ID (Standard Component ID)	Total 419420C0010000 419420C0010000 419420C0010000 419420C001002 419420C0010000 419420C0010002 419420C0010002 419420C0010002	10064 418400C0000778 41840C0000000 41840C00000000 41840C0000000000000000000000000000000000	\$150,000,000 \$154,
\$52,643,233 2.2 Allowed Claims \$0 2.3 Reinsurance	\$52,842,233 \$17,040,944 \$4,228,977 \$5,634,077 \$4,337,225 \$9 \$5,235,844 \$4,655,647 \$4,846,245 \$937,1 co co c	27,227 \$100,209 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	\$150,667 \$523,266 \$1,360,966 \$137,553 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0
2.4 Member Cost Sharine	\$7,28,004 \$2,200,000 \$517,441 \$466,581 \$296,728 \$0 \$000,000 \$506,703 \$723,110 \$181,1	50 50 50 50 50 50 50 50 50 50 50 50 50 5	\$2555 \$50.712 \$200.777 \$27.837 \$0 \$0 \$0 \$115.206 \$126.131 \$0 \$00.055 \$23.05 \$0
2.5 Cost Sharing Reduction	50 50 50 50 50 50 50	50 50 50 50 50 50 50 50 50 50 50 50 50 5	50 50 50 50 50 50 50 50 50 50 50 50 50 5
\$45,608,199 2.6 Incurred Claims -\$721,536 2.7 Risk Adjustment Transfer Amount	5721.516 50 5111.47N 5120.085 5106.731 50 594.000 586.748 572.473 522	22.459 -50.155 50 50 50 50 50 50 50 50 50 50 50 50	-C1864 -C5.886 -C5.886 -C5.686 -C5.478 -C0 -C0 -C5
\$56,158,345 2.8 Premium	\$54,150,365 \$18,103,990 \$5,879,220 \$6,860,800 \$5,629,061 \$0 \$4,858,097 \$4,575,153 \$3,875,084 \$1,181,1		
127,463 2.9 Experience Period Member Months 2.10 Current Enrollment	127,667 40,987 11,036 12,708 10,709 0 11,472 11,086 10,065 2,0 11,694 2,967 1,203 1,205 1,348 0 1,096 990 1,120	2,322 1,465 0 0 0 0 0 0 0 2,095 846 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	460 727 1,656 669 0 0 0 1,522 1,660 0 1,058 228 0 0 0 0 1 1,522 1,660 0 1,058 228 0 0 0 0 1 1,522 0 0 0 1 1,00
2.11 Current Premium PMPM	\$434.32 \$439.57 \$471.50 \$470.16 \$535.79 \$0.00 \$445.67 \$388.10 \$383.97 \$412	12.57 522531 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00	\$465.22 \$415.81 \$272.00 \$151.85 \$0.00 \$0.00 \$0.00 \$366.60 \$1218.95 \$0.00 \$325.94 \$248.46 \$0.00
2.12 Loss Partio Per Member Per Month	22.27% 81.96% 98.68% 76.63% 71.18% #00/y0/ 90.99% 22.52% 90.89% 65.2	5.23% 55.26% eCIV/OI e	75 100 165 365 82.425 49.565 HOLYOI MONYOI MONYOI MONYOI 64.215 20.595 MONYOI 62.455 21.625 MONYOI
2.13 Allowed Claims		221.16 S203.30 #DWO! #DWO! #DWO! #DWO! #DWO! #DWO! #DWO! \$20.001 S241.71 S223.36 #DWO! #DWO!	SEC 25 270.00 STR-20 SEC.01 400/00 400/00 400/00 SEC.02 SEC.00 400/00 SEC.00 500/00 SEC.00 500/00 SEC.00 500/00
2.14 Reinsurance		50.00 \$0.00 #CH/OT #CH/	\$2.00 \$2.00
2.15 Member Cost Sharing 2.16 Cost Sharing Reduction		56.00 50.00 \$50.	\$21.72 \$26.75 \$7.00 \$24.14 \$90,000 \$90,000 \$75.26 \$46.04 \$90,000 \$32.24 \$90,000 \$
2.17 Incurred Claims	\$157.82 \$362.81 \$476.91 \$376.25 \$274.52 #00/01 \$385.80 \$318.68 \$343.28 \$267	267.07 \$177.50 #DIV/DI #DIV/DI #DIV/DI #DIV/DI #DIV/DI #DIV/DI #DIV/DI \$221.44 \$89.47 #DIV/DI #DIV/DI	\$341.23 \$683.23 \$316.63 \$171.67 #DN/OI #DN/OI \$236.33 \$154.13 #DN/OI \$206.99 \$57.97 #DN/OI
2.18 Risk Adjustment Transfer Amount 2.19 Premium	55.66 50.00 59.36 59.00 59.30 59.00 59.00 59.00 59.00 59.00 57.40 57.30 57.40 59.00 590.00 59	57.91 -55.72 800/00 800/02 800/00 800/00 800/00 800/00 -56.44 -56.29 800/00 800/00 17.22 20.55 800/00 800/0	56273 57296 57242 58143 51246 600/00 80/000 80/000 52753 53569 80/000 52474 5518 80/000 5414 5518 80/000 5414 5518 80/000 5414 5518 80/000 5414 5518 80/000 5414 5414 5414 5414 5414 5414 5414 5
Section III: Plan Adjustment Factors 3.1 Plan ID (Standard Component ID)	COMMODELL COMMOD	CONTROCARIA DOSCONOCIANA DECONOCIANA DOSCONOCIANA DOSCONO	4384CDC0000000 43842CDC000000 43842CDC000000 43842CDC000000 43842CC000000 43842CC00000
3.2 Market Adjusted Index Rate		\$497.51	
3.3 Alf and Cost Sharing Design of Plan 3.4 Provider Network Adjustment	0.0000 0.9407 0.9965 1.0366 0.0216 0.0216 0.7004 0.7710 0.77	77004 0.0222 0.7070 0.7003 0.6408 0.6015 0.7074 0.5125 0.6288 0.5562 0.5561 0.0000	0.0003 0.0003 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000000
2.5 Benefits in Addition to EHB	0.0000 1.0150 1.0150 1.0150 1.0150 1.050 1.0150 1.0150 1.0150	10150 10150 10150 10150 10150 10150 10150 10150 10150 10150 10150 10150 10150	10000 100000 100000 100000 10000 10000 10000 100000 10000 10000 10000 10000 10
Administrative Costs 2.6 Administrative Expense	0.00% 9.41% 9.41% 9.41% 9.41% 9.41% 9.41% 9.41% 9.41%	0.00	2475 S475 9475 9475 9475 9475 9475 9475 9475 9
3.7 Taxes and Fees	0.00% 7.09% 7.09% 7.09% 7.09% 7.09% 7.09% 7.09% 7.09% 7.09%	7.09% 7.09%	7.09% 7.09%
3.8 Profit & Risk Load 3.9 Catastrophic Adjustment	0.00% 2.04%	30FK 20FK 20FK 20FK 20FK 20FK 20FK 20FK 2	200K 200K 200K 200K 200K 200K 200K 200K
3.10 Plan Adjusted Index Rate	20,00 500120 500541 5546.28 5511.00 5510.00 5410.58 5401.50 5410	00-51 5556-55 5481.37 540-77 5407.92 5433.99 5440.97 5381.41 5400.92 5353.5 5354.66 #00/07	\$881.35 \$655.87 \$464.78 \$551.27 \$471.77 \$402.90 \$400.48 \$401.35 \$302.88 \$348.51 \$348.64 \$205.00 \$400.00
3.11 Am Calibration Factor	0,9727	9777	1
3.12 Geographic Calibration Factor	1,0000	1,000	
3.13 Tobacco Calibration Factor 3.14 Calibrated Plan Adjusted Index Rate	1,0000 CO 00 CO 277 CO 00 M CO	1,0000 17758 50754 646573 6470.76 536.60 6477.16 5477.16 5477.16 5477.16 5477.16 5477.16 5477.16 5477.16	555.48 509.05 547.69 549.44 5458.8 547.17 589.54 540.08 537.15 539.00 530.12 536.68 400.00
	The second secon		
Section IV: Projected Plan Level Information 4.1 Plan ID (Standard Component ID)	Total 418400/0010000 418420/0010006 418420/0010008 418420/0010074 418420/0010007 418420/0010006 418420/001002 418420/001002 418420/001002	10054 41840C000079 41840C001001	41840C0090009 41843C0000000 41843C0000000 41843C0000000 41843C00000000 41843C00000000 41843C00000000 41843C00000000 41843C00000000 41843C00000000 41843C00000000 41843C00000000 41843C000000000000000000000000000000000000
4.2 Allowed Claims	\$62,679,634 50 \$9,844,000 \$11,222,494 \$8,856,153 \$5556,600 \$51,368,855 \$6,156,477 \$5,403,890 \$1,635,1	25 866	\$600.002 \$1.120.010 \$2.054.001 \$500.070 \$100.502 \$100.502 \$500.502 \$1.051.120 \$64.000 \$520.461 \$440.00 \$0
4.3 Reinsurance 4.4 Member Cost Sharina	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$	50 50 50 50 50 50 50 50 50 50 50 50 50 5	50 50 50 50 50 50 50 50 50 50 50 50 50 5
4.5 Cost Sharing Reduction		50 50 50 50 50 50 50 50 50 50 50	
4.6 Incurred Claims 4.7 Risk Adjustment Transfer Amount	\$52,712,572 \$0 \$8,670,000 \$10,475,676 \$8,677,115 \$412,580 \$5,196,580 \$4,516,645 \$4,055,131 \$1,102 -51,786,700 \$0 \$206,771 \$226,784 \$188,120 \$11,600 \$642,230 \$144,616 \$126,118 \$383	10,295 500,0,145 5120,177 5117,246 5100,000 5115,577 51117,246 500,000 5115,577 51117,245 500,240 51,500,863 5465,733 546,122 50 83,728 52,7266 52,746 52,748 52,74	579,000 \$1,000,60 \$1,515,00 \$611,50 \$11,50 \$15,610 \$115,00 \$115,00 \$100,60 \$600,601 \$610,601 \$511,00 \$511,00 \$511,00 \$500,00 \$0 \$510,00 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$
4.8 Premium	\$67.701.701 50 \$11.140.000 \$13.454.455 \$11.001.045 \$336.807 \$56.773.80 \$5.801.084 \$2.207.877 \$1.511.0	21.487 \$1.027.600 \$164.610 \$150.742 \$120.479 \$148.425 \$151.827 \$121.468 \$1.478.175 \$527.471 \$69.514 \$0	\$1,001,070 \$1,222,000 \$1,040,000 \$55,4200 \$55,4200 \$1,040,000 \$1,0
4.9 Projected Member Months 4.30 Loss Ratio	127,651 0 18,868 21,513 17,167 1,067 13,070 13,187 11,099 3,0 79,509 #50/01 78,149 76,259 76,259 76,519 76,579 76,679 78,859 76,879	2,484 1,689 342 347 342 342 342 342 342 342 342 345 1,611 166 5 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	1,722 2,466 4,325 1,068 340 340 340 340 2,061 2,079 566 1,882 868 0 73.286 73.287 73.288 73.2
Per Member Per Month			
4.11 Allowed Claims 4.12 Reinsurance		802.54 \$402.54 \$402.54 \$400.54	931.77 (521.77) (521.
4.12 Member Cost Sharing	\$78.19 MOV/01 \$62.01 \$34.76 \$18.58 \$115.35 \$71.96 \$127.29 \$117.19 \$127.	127.29 S67.66 S94.75 S136.38 S151.98 S131.61 S121.88 S170.22 S121.28 S152.74 S157.28 MONUN	599.07 542.08 5122.21 570.20 5102.22 5122.40 5157.70 5123.60 5127.54 5162.09 5161.07 5162.00 #DIV/OI
4.14 Cost Sharing Reduction	\$0.00 MDIV/DI \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	SADD SADD SADD SADD SADD SADD SADD SADD	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00
4.15 Incurred Claims 4.16 Risk Adjustment Transfer Amount		10.00 S10.00	
417 Premiers	\$333.15 #50V(0) \$590.26 \$625.41 \$566.18 \$523.90 \$510.62 \$423.58 \$462.50 \$410	100.51 5556.55 5485.27 5480.77 5407.00 5430.00 5445.07 5384.41 5000.02 5255.55 5554.65 8504.00	\$281.25 \$655.87 \$484.79 \$531.27 \$477.77 \$432.00 \$400.00 \$431.21 \$292.00 \$400.00 \$400.00

Rating Area Data Collection

Rating Area	Rating Factor
Rating Area 1	1.0000

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Scope and Range of the Increase:				
Rate Filing Type	Rate Increase New Filing			
Market Type	Individual	Small Group		
Product Name	Medical and Pre	escription Drug Insurance		
Submission Date	May 24, 2019			
SERFF tracking number	UHLC-1319099	UHLC-131909980		
Name of Company	UnitedHealthcar	UnitedHealthcare Insurance Company		

The 11.2% increase is requested because:

The biggest drivers of our rate increase is trend and the return of the ACA fees.

This filing will impact:

of policyholder's 1674 # of covered lives 11950

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 11.2 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved 5.9 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 15.6%

Individuals within the group may vary from the aggregate of the above increase components as a result of:

The group's rate is based on the benefit plan selected and the attained ages of the members at the beginning of the policy period.

Financial Experience of Product

The overall financial experience of the product includes:

Some membership growth but an increase in trend.

The rate increase will affect the projected financial experience of the product by:

The projected loss ratio using the Federal prescribed MLR methodology is 86.2%

Components of Increase

The request is made up of the following components:

Trend Increases – 8.1 % of the 11.2 % total filed increase

1. Medical Utilization Changes –Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

This component is 4.2% of the 11.2% total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

This component is 3.9% of the 11.2% total filed increase.

Other Increases – 2.9 % of the 11.2 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

This component is % of the % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

This component is -1.6 % of the 11.2% total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

This component is 1.4 % of the 11.2% total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

This component is % of the % total filed increase.

5. Other – Defined as:

Base rate increase.

Note: Components are multiplicative, so sum may differ slightly from total rate increase %.

This component is 3.1 % of the 11.2 % total filed increase.

RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP PLANS SOLD ON DC HEALTH LINK CHECK-LIST

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.	Yes	Actuarial Memo
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.	Yes	Actuarial Memo
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.	Yes	Actuarial Memo
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2017 and later, follow filing due date requirements.	Yes	Actuarial Memo
5	Market	Indicate whether the products are sold in the individual or small employer group market.	Yes	Actuarial Memo
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non-grandfathered, or a mixture of both.	Yes	Actuarial Memo
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.	Yes	Actuarial Memo

Number	r Data Element Requirement Description		Individual and Sma	all Group
			Has the Data Element Been Included?	Location of the Data Element
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.	Yes	Exhibit 1
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. In the small group market, please also provide weighted average rate increase requested for 2016Q1 over 2015Q1; etc.	Yes	Actuarial Memo
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	Actuarial Memo
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	Actuarial Memo
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.	Yes	Actuarial Memo
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.	Yes	Actuarial Memo
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for District of Columbia and the nationwide average rate history.	Yes	Actuarial Memo
14	Exposure	Current number of policies, certificates and covered lives.	Yes	Actuarial Memo

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.	Yes	Exhibit A
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.	Yes	Exhibit A
17	Index Rate	Provide the index rate.	Yes	Actuarial Memo
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.	Yes	Actuarial Memo
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.	Yes	Actuarial Memo
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.	Yes	Exhibit T
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.	Yes	Actuarial Memo Exhibit 4
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.	Yës	Actuarial Memo Exhibit 4

Number	Data Element	Requirement Description Individual and Small Grou		ll Group
			Has the Data Element Been Included?	Location of the Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders.	Yes	Actuarial Memo Exhibit 3
		For initial filings, provide the derivation of any new plan factors.		
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.	Yes	Actuarial Memo Exhibit 1 Exhibit 3
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.	Yes	Actuarial Memo
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.	Yes	DISB Actuarial Memo Dataset
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.	Yes	Actuarial Memo Exhibit A Part III Act'l Memo
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation. Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	Actuarial Memo

Number	Data Element	Requirement Description	Individual/and Sm	all Group
			Has the Data Element Been Included?	Location of the Data Element
27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	Actuarial Memo
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in District of Columbia, the loss ratio meets the minimum.	Yes	Actuarial Memo
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative support for the amount.	Yes	Actuarial Memo

Number	Data Element	Data Element Requirement Description	Individual and Sm:	all Group
			Has the Data Element Been Included?	Location of the Data Element
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.	Yes	Actuarial Memo
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.	Yes	Actuarial Memo

Number	Data Element	Requirement Description	Individual and Sma	all Group
			Has the Data Element Been Included?	Location of the Data Element
32	Past and Prospective Expenses	Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change. Provide the assumed administrative costs in the following categories: Salaries, wages, employment taxes, and other employee benefits Commissions Taxes, licenses, and other regulatory fees Cost containment programs / quality improvement activities All other administrative expenses Total	Yes	Actuarial Memo
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.	Yes	Actuarial Memo
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.	Yes	Actuarial Memo
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of the District of Columbia and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.	Yes	Actuarial Memo

Number Data Element Requirement Description		Requirement Description	Individual and Sma	ıll Group	
			Has the Data Element Been Included?	Location of the Data Element	
36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet Provide this document with all Grandfathered plan filings. Provide in Excel and PDF format.	N/a	N/a	
36.1	Unified Rate Review Template (Non- Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. Provide in Excel and PDF format.	Yes	Separate Document in SERFF	
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for <i>all</i> individual and small employer group filings (whether or not they are "subject to review" as defined by HHS).	Yes	Separate Document in SERFF	
38	DISB Actuarial Memorandum Dataset	Summarizes data elements contained in Actuarial Memorandum. Provide this document with all Non-Grandfathered plan filings. Provide in Excel format only.	Yes	Separate Document in SERFF	
39	District of Columbia Plain Language Summary	Similar to the Part II Preliminary Justification, this is a written description of the rate increase as specified by 45 CFR § 154.215, but as a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. Provide this document for all individual and small employer group filings.	Yes	Separate Document in SERFF	
40	Summary of Components for Requested Rate Change	DISB will require that issuers provide a chart listing a) any and all components of requested rate changes from the prior year; b) a quick summary/explanation of the change; and c) the actual percentage impact of the change for each component, such that the total for all components listed equals the total percentage change requested for the plan year.	Yes	Exhibit 3	

Number	Data Element	Requirement Description	Individual and Sm	all Group
			Has the Data Element Been Included?	Location of the Data Element
41	CCIIO Risk Adjustment Transfer Elements Extract (RATE 'E')	Received directly from CCIIO; this report should be completed and submitted by the set deadline for QHP submissions, or by April 30 th of the current year, whichever is first.	Yes	Supporting Docs in SERFF
42	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: • Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule; • Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and • Demonstration that the plan has a reasonable annual limitation on cost-sharing.	N/a	N/a

CERTIFYING SIGNATURE

The undersigned representative of the organization submitting	ng this rate filing attests that all items contained in the above
checklist have been included in the filing to the best of the con	npany's ability.
Ryan Morgan	Myan Morgan
(Print Name)	(Signature)

Page Number	Tracking Number	Plan Name	Run Number	Run AV	Run Weight	Final AV	Final Metal Level
4	Bronze 4 CH - 2020	BH-E3	1	62.6%	100.0%	62.6%	Bronze
5	Gold 1 CH - 2020	BH-EZ	1	81.3%	100.0%	81.3%	Gold
6	Gold 1 CH+ - 2020	BH-E6	1	81.3%	100.0%	81.3%	Gold
7	Gold 22_Copay CH - 2020	BQ-AK	1	79.0%	60.6%	81.1%	Gold
8	Gold 22_Copay CH - 2020	BQ-AK	2	80.9%	9.4%	81.1%	Gold
9	Gold 22_Copay CH - 2020	BQ-AK	3	84.8%	26.0%	81.1%	Gold
10	Gold 22_Copay CH - 2020	BQ-AK	4	87.5%	4.0%	81.1%	Gold
11	Gold 29 CH+ - 2020	BQ-AL	1	79.6%	86.6%	79.8%	Gold
12	Gold 29 CH+ - 2020	BQ-AL	2	80.9%	13.4%	79.8%	Gold
13	Gold 22_Copay CH+ - 2020	BQ-AM	1	79.0%	60.6%	81.1%	Gold
14	Gold 22_Copay CH+ - 2020	BQ-AM	2	80.9%	9.4%	81.1%	Gold
15	Gold 22_Copay CH+ - 2020	BQ-AM	3	84.8%	26.0%	81.1%	Gold
16	Gold 22_Copay CH+ - 2020	BQ-AM	4	87.5%	4.0%	81.1%	Gold
17	Gold 28 CH+ - 2020	BQ-AN	1	81.8%	86.6%	81.9%	Gold
18	Gold 28 CH+ - 2020	BQ-AN	2	82.4%	13.4%	81.9%	Gold
19	Gold 7 CH+ - 2020	BQ-AO	1	81.4%	100.0%	81.4%	Gold
20	Plat 14 CH+ - 2020	BQ-AQ	1	88.8%	51.0%	91.2%	Platinum
21	Plat 14 CH+ - 2020	BQ-AQ	2	93.7%	49.0%	91.2%	Platinum
22	Plat 15 CH+ - 2020	BQ-AR	1	86.1%	86.6%	86.3%	Platinum
23	Plat 15 CH+ - 2020	BQ-AR	2	87.3%	13.4%	86.3%	Platinum
24	Gold 23 CH_Primary Advantage - 2020	BQ-AW	1	79.7%	86.6%	79.9%	Gold
25	Gold 23 CH_Primary Advantage - 2020	BQ-AW	2	81.4%	13.4%	79.9%	Gold
26	Gold 23 CH+_Primary Advantage - 2020	BQ-AX	1	79.7%	86.6%	79.9%	Gold
27	Gold 23 CH+_Primary Advantage - 2020	BQ-AX	2	81.4%	13.4%	79.9%	Gold
28	Gold 31_CH+ Primary Advantage - 2020	BQ-AY	1	75.9%	86.6%	76.0%	Gold
29	Gold 31_CH+ Primary Advantage - 2020	BQ-AY	2	77.1%	13.4%	76.0%	Gold
30	Silver 19_CH Primary Advantage - 2020	BQ-AZ	1	71.8%	86.6%	72.0%	Silver
31	Silver 19_CH Primary Advantage - 2020	BQ-AZ	2	73.3%	13.4%	72.0%	Silver
32	Silver 19_CH+ Primary Advantage - 2020	BQ-A2	1	71.8%	86.6%	72.0%	Silver
33	Silver 19_CH+ Primary Advantage - 2020	BQ-A2	2	73.3%	13.4%	72.0%	Silver
34	Platinum 01 CH+ - 2020	BQ-A3	1	90.1%	17.2%	89.6%	Platinum
35	Platinum 01 CH+ - 2020	BQ-A3	2	91.9%	2.7%	89.6%	Platinum
36	Platinum 01 CH+ - 2020	BQ-A3	1	88.7%	35.4%	89.6%	Platinum
37	Platinum 01 CH+ - 2020	BQ-A3	2	90.0%	5.5%	89.6%	Platinum
38	Platinum 01 CH+ - 2020	BQ-A3	3	89.7%	34.0%	89.6%	Platinum
39	Platinum 01 CH+ - 2020	BQ-A3	4	91.3%	5.3%	89.6%	Platinum
40	Gold 13 CH - 2020	BQ-A5	1	83.5%	17.2%	81.5%	Gold
41	Gold 13 CH - 2020	BQ-A5	2	84.3%	2.7%	81.5%	Gold
42	Gold 13 CH - 2020	BQ-A5	1	79.1%	35.4%	81.5%	Gold
43	Gold 13 CH - 2020	BQ-A5	2	80.4%	5.5%	81.5%	Gold
44	Gold 13 CH - 2020	BQ-A5	3	82.6%	34.0%	81.5%	Gold
45	Gold 13 CH - 2020	BQ-A5	4	83.5%	5.3%	81.5%	Gold
46	Gold 10 CH+ - 2020	BQ-A6	1	82.4%	17.2%	81.2%	Gold
47	Gold 10 CH+ - 2020	BQ-A6	2	83.3%	2.7%	81.2%	Gold
48	Gold 10 CH+ - 2020	BQ-A6	1	79.7%	35.4%	81.2%	Gold
49	Gold 10 CH+ - 2020	BQ-A6	2	80.9%	5.5%	81.2%	Gold
50	Gold 10 CH+ - 2020	BQ-A6	3	81.9%	34.0%	81.2%	Gold
51	Gold 10 CH+ - 2020	BQ-A6	4	82.8%	5.3%	81.2%	Gold
52	Gold 26 CH - 2020	BQ-A7	1	77.2%	7.5%	77.6%	Gold
53	Gold 26 CH - 2020	BQ-A7	2	78.4%	1.2%	77.6%	Gold

54	Gold 26 CH - 2020	BQ-A7	3	79.1%	7.2%	77.6%	Gold
55	Gold 26 CH - 2020	BQ-A7	4	79.9%	1.1%	77.6%	Gold
56	Gold 26 CH - 2020	BQ-A7	5	77.3%	1.3%	77.6%	Gold
57	Gold 26 CH - 2020	BQ-A7	6	78.5%	0.2%	77.6%	Gold
58	Gold 26 CH - 2020	BQ-A7	7	79.3%	1.3%	77.6%	Gold
59	Gold 26 CH - 2020	BQ-A7	8	80.1%	0.2%	77.6%	Gold
60	Gold 26 CH - 2020	BQ-A7	1	75.9%	30.1%	77.6%	Gold
61	Gold 26 CH - 2020	BQ-A7	2	77.2%	4.7%	77.6%	Gold
62	Gold 26 CH - 2020	BQ-A7	3	78.7%	28.9%	77.6%	Gold
63	Gold 26 CH - 2020	BQ-A7	4	79.6%	4.5%	77.6%	Gold
64	Gold 26 CH - 2020	BQ-A7	5	76.0%	5.3%	77.6%	Gold
65	Gold 26 CH - 2020	BQ-A7	6	77.3%	0.8%	77.6%	Gold
66	Gold 26 CH - 2020	BQ-A7	7	78.9%	5.1%	77.6%	Gold
67	Gold 26 CH - 2020	BQ-A7	8	79.8%	0.8%	77.6%	Gold
68	Gold 8 CH+ -2020	BQ-A8	1	82.4%	17.2%	81.8%	Gold
69	Gold 8 CH+ -2020	BQ-A8	2	83.3%	2.7%	81.8%	Gold
70	Gold 8 CH+ -2020	BQ-A8	1	81.0%	35.4%	81.8%	Gold
71	Gold 8 CH+ -2020	BQ-A8	2	82.1%	5.5%	81.8%	Gold
72	Gold 8 CH+ -2020	BQ-A8	3	82.0%	34.0%	81.8%	Gold
73	Gold 8 CH+ -2020	BQ-A8	4	83.0%	5.3%	81.8%	Gold
74	Gold 8 CH -2020	BQ-A9	1	82.4%	17.2%	81.8%	Gold
75	Gold 8 CH -2020	BQ-A9	2	83.3%	2.7%	81.8%	Gold
76	Gold 8 CH -2020	BQ-A9	1	81.0%	35.4%	81.8%	Gold
77	Gold 8 CH -2020	BQ-A9	2	82.1%	5.5%	81.8%	Gold
78	Gold 8 CH -2020	BQ-A9	3	82.0%	34.0%	81.8%	Gold
79	Gold 8 CH -2020	BQ-A9	4	83.0%	5.3%	81.8%	Gold
80	Gold 13 CH+ - 2020	BQ-BA	1	83.5%	17.2%	81.5%	Gold
81	Gold 13 CH+ - 2020	BQ-BA	2	84.3%	2.7%	81.5%	Gold
82	Gold 13 CH+ - 2020	BQ-BA	1	79.1%	35.4%	81.5%	Gold
83	Gold 13 CH+ - 2020	BQ-BA	2	80.4%	5.5%	81.5%	Gold
84	Gold 13 CH+ - 2020	BQ-BA	3	82.6%	34.0%	81.5%	Gold
85	Gold 13 CH+ - 2020	BQ-BA	4	83.5%	5.3%	81.5%	Gold
86	Platinum 01 CH - 2020	BQ-BB	1	90.1%	17.2%	89.6%	Platinum
87	Platinum 01 CH - 2020	BQ-BB	2	91.9%	2.7%	89.6%	Platinum
88	Platinum 01 CH - 2020	BQ-BB	1	88.7%	35.4%	89.6%	Platinum
89	Platinum 01 CH - 2020	BQ-BB	2	90.0%	5.5%	89.6%	Platinum
90	Platinum 01 CH - 2020	BQ-BB	3	89.7%	34.0%	89.6%	Platinum
91	Platinum 01 CH - 2020	BQ-BB	4	91.3%	5.3%	89.6%	Platinum
92	Gold 26 CH+ - 2020	BQ-BC	1	77.2%	7.5%	77.6%	Gold
93	Gold 26 CH+ - 2020	BQ-BC	2	78.4%	1.2%	77.6%	Gold
94	Gold 26 CH+ - 2020	BQ-BC	3	79.1%	7.2%	77.6%	Gold
95	Gold 26 CH+ - 2020	BQ-BC	4	79.9%	1.1%	77.6%	Gold
96	Gold 26 CH+ - 2020	BQ-BC	5	77.3%	1.3%	77.6%	Gold
97	Gold 26 CH+ - 2020	BQ-BC	6	78.5%	0.2%	77.6%	Gold
98	Gold 26 CH+ - 2020	BQ-BC	7	79.3%	1.3%	77.6%	Gold
99	Gold 26 CH+ - 2020	BQ-BC	8	80.1%	0.2%	77.6%	Gold
100	Gold 26 CH+ - 2020	BQ-BC	1	75.9%	30.1%	77.6%	Gold
101	Gold 26 CH+ - 2020	BQ-BC	2	77.2%	4.7%	77.6%	Gold
102	Gold 26 CH+ - 2020	BQ-BC	3	78.7%	28.9%	77.6%	Gold
103	Gold 26 CH+ - 2020	BQ-BC	4	79.6%	4.5%	77.6%	Gold
104	Gold 26 CH+ - 2020	BQ-BC	5	76.0%	5.3%	77.6%	Gold
105	Gold 26 CH+ - 2020	BQ-BC	6	77.3%	0.8%	77.6%	Gold

106	Gold 26 CH+ - 2020	BQ-BC	7	78.9%	5.1%	77.6%	Gold
107	Gold 26 CH+ - 2020	BQ-BC	8	79.8%	0.8%	77.6%	Gold
108	Platinum 04 CH - 2020	BQ-BD	1	90.8%	17.2%	88.7%	Platinum
109	Platinum 04 CH - 2020	BQ-BD	2	93.1%	2.7%	88.7%	Platinum
110	Platinum 04 CH - 2020	BQ-BD	1	85.5%	35.4%	88.7%	Platinum
111	Platinum 04 CH - 2020	BQ-BD	2	87.2%	5.5%	88.7%	Platinum
112	Platinum 04 CH - 2020	BQ-BD	3	90.3%	34.0%	88.7%	Platinum
113	Platinum 04 CH - 2020	BQ-BD	4	92.5%	5.3%	88.7%	Platinum
114	Silver 8 CH+ - 2020	BQ-BE	1	70.9%	0.6%	71.8%	Silver
115	Silver 8 CH+ - 2020	BQ-BE	2	72.4%	0.1%	71.8%	Silver
116	Silver 8 CH+ - 2020	BQ-BE	3	72.6%	0.6%	71.8%	Silver
117	Silver 8 CH+ - 2020	BQ-BE	4	73.7%	0.1%	71.8%	Silver
118	Silver 8 CH+ - 2020	BQ-BE	5	71.8%	8.2%	71.8%	Silver
119	Silver 8 CH+ - 2020	BQ-BE	6	73.2%	1.3%	71.8%	Silver
120	Silver 8 CH+ - 2020	BQ-BE	7	71.8%	7.9%	71.8%	Silver
121	Silver 8 CH+ - 2020	BQ-BE	8	73.2%	1.2%	71.8%	Silver
122	Silver 8 CH+ - 2020	BQ-BE	1	70.2%	4.9%	71.8%	Silver
123	Silver 8 CH+ - 2020	BQ-BE	2	71.7%	0.8%	71.8%	Silver
124	Silver 8 CH+ - 2020	BQ-BE	3	71.7%	64.5%	71.8%	Silver
125	Silver 8 CH+ - 2020	BQ-BE	4	73.1%	10.0%	71.8%	Silver
126	Silver 11 CH - 2020	BQ-BF	1	73.1%	16.9%	71.6%	Silver
127	Silver 11 CH - 2020	BQ-BF	2	73.4%	3.0%	71.6%	Silver
128	Silver 11 CH - 2020	BQ-BF	1	69.9%	34.7%	71.6%	Silver
129	Silver 11 CH - 2020	BQ-BF	2	72.5%	33.4%	71.6%	Silver
130	Silver 11 CH - 2020	BQ-BF	3	70.0%	6.1%	71.6%	Silver
131	Silver 11 CH - 2020	BQ-BF	4	72.7%	5.9%	71.6%	Silver
132	Silver 11 CH+ - 2020	BQ-BG	1	73.1%	16.9%	71.6%	Silver
133	Silver 11 CH+ - 2020	BQ-BG	2	73.4%	3.0%	71.6%	Silver
134	Silver 11 CH+ - 2020	BQ-BG	1	69.9%	34.7%	71.6%	Silver
135	Silver 11 CH+ - 2020	BQ-BG	2	72.5%	33.4%	71.6%	Silver
136	Silver 11 CH+ - 2020	BQ-BG	3	70.0%	6.1%	71.6%	Silver
137	Silver 11 CH+ - 2020	BQ-BG	4	72.7%	5.9%	71.6%	Silver
138	Silver 8 CH - 2020	BQ-BI	1	70.9%	0.6%	71.8%	Silver
139	Silver 8 CH - 2020	BQ-BI	2	72.4%	0.1%	71.8%	Silver
140	Silver 8 CH - 2020	BQ-BI	3	72.6%	0.6%	71.8%	Silver
141	Silver 8 CH - 2020	BQ-BI	4	73.7%	0.1%	71.8%	Silver
142	Silver 8 CH - 2020	BQ-BI	5	71.8%	8.2%	71.8%	Silver
143	Silver 8 CH - 2020	BQ-BI	6	73.2%	1.3%	71.8%	Silver
144	Silver 8 CH - 2020	BQ-BI	7	71.8%	7.9%	71.8%	Silver
145	Silver 8 CH - 2020	BQ-BI	8	73.2%	1.2%	71.8%	Silver
146	Silver 8 CH - 2020	BQ-BI	1	70.2%	4.9%	71.8%	Silver
147	Silver 8 CH - 2020	BQ-BI	2	71.7%	0.8%	71.8%	Silver
148	Silver 8 CH - 2020	BQ-BI	3	71.7%	64.5%	71.8%	Silver
149	Silver 8 CH - 2020	BQ-BI	4	73.1%	10.0%	71.8%	Silver
150	Platinum 04 CH+ - 2020	BQ-BJ	1	90.8%	17.2%	88.7%	Platinum
151	Platinum 04 CH+ - 2020	BQ-BJ	2	93.1%	2.7%	88.7%	Platinum
152	Platinum 04 CH+ - 2020	BQ-BJ	1	85.5%	35.4%	88.7%	Platinum
153	Platinum 04 CH+ - 2020	BQ-BJ	2	87.2%	5.5%	88.7%	Platinum
154	Platinum 04 CH+ - 2020	BQ-BJ	3	90.3%	34.0%	88.7%	Platinum
155	Platinum 04 CH+ - 2020	BQ-BJ	4	92.5%	5.3%	88.7%	Platinum
	riddingin or orn 2020	200	-	52.070	3.070	55.70	· idiiidiii

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		l Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6't D-		_	T'	2 Dl D 6't F	N			
	Medical	1 Plan Benefit De Drug	Combined	-	Medical	2 Plan Benefit I Drug	Combined			
Deductible (\$)		Diug	\$6,700.00		Wedical	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	 						
MOOP if Separate (\$)			70,:00:00	-			·			
,			_				•			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductib
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	✓ All	✓ All			All	All			□ All	☐ All
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	✓✓								
All impatient hospital services (inc. Min/SOD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓	✓								
Specialist Visit	V	V								
Mental/Behavioral Health and Substance Use Disorder Outpatient	_		······································		_	_				_
Services	V	✓								
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	V	V								
	✓	V								
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services	V	<u> </u>			-					
X-rays and Diagnostic Imaging	V	V				H				
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	✓ All			☐ All	☐ All			☐ All	☐ All
Generics	V	V								
Preferred Brand Drugs	V	V								
Non-Preferred Brand Drugs	V	V								
Specialty Drugs (i.e. high-cost)	V	~								
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-E3						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004000	8-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Expanded Bronze S	tandard (56% to 6	55%), Calculation S	uccessful.						
Actuarial Value:	62.59%									
Metal Tier:	Bronze									
A Little Control of the Control of t										
Additional Notes:										
a. I. I. I										
Calculation Time: Final 2020 AV Calculator	0.4375 seconds									
rinai zuzu Av Caiculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Option:	s	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bation Amount.		2nd	Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De				2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$1,400.00							
Coinsurance (%, Insurer's Cost Share)			90.00%	_						
MOOP (\$)			\$3,500.00							
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	y after deductible?
••	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	✓ All	✓ All			☐ All	☐ All			□ All	☐ All
Emergency Room Services	<u> </u>									
All Inpatient Hospital Services (inc. MH/SUD)	V	✓			Ш					
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓	•								
Specialist Visit	V	✓								
Mental/Behavioral Health and Substance Use Disorder Outpatient					_	_				_
Services	✓	✓								
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	V	V								
	✓	V								
Occupational and Physical Therapy						_			0	_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	~	✓								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	₹.	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☑ All	☐ All			☐ All	☐ All			☑ All	☐ All
Generics	V			\$10.00					✓	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	✓			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-EZ						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output # Copays (1-10):										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	81.33%									
Metal Tier:	Gold									
Additional Notes:										
Calculation Time: Final 2020 AV Calculator	0.0312 seconds									
Tillal LoLo AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	5	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?					1st	Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	ibution Amount:		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
		Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		Diug	\$1,400.00		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)			90.00%							
MOOP (\$)			\$3,500.00	+						
MOOP if Separate (\$)			\$3,300.00	4		T	-			
WOOF II Separate (3)							1			
Click Here for Important Instructions		Tie	er 1			T	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Conay applies onl	y after deductible?
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies offi	, arter deductible:
Medical	☑ All	✓ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	✓	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	V	V								
Specialist Visit	V	✓								
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	~	✓								
Imaging (CT/PET Scans, MRIs)	✓	V								
Speech Therapy										
Occupational and Physical Therapy	✓	V								
Preventive Care/Screening/Immunization		П		\$0.00						
Laboratory Outpatient and Professional Services	<u> </u>			30.00						
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	V	<u> </u>				H				
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•								
Outpatient Surgery Physician/Surgical Services	V	☑								
Drugs	✓ All	☐ All			□All	□ All			☑ All	□ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	<u> </u>			\$40.00					✓	
Non-Preferred Brand Drugs	☑			\$75.00					☑	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00					<u> </u>	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-E6						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	101					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output # Copays (1-10):										
Calculate										
	Calculation Successi	S. I								
Status/Error Messages:	81.33%	ui.								
Actuarial Value:										
Metal Tier:	Gold									
Additional Notes:										
Additional NOTES:										
Calculation Time:	0.0312 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Dlan Banafit Da	alaa	_	Tion	2 Dlan Danafit I	Danier			
	Medical	1 Plan Benefit De Drug	Combined	-	Medical	2 Plan Benefit I Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)						1				
MOOP if Separate (\$)				-						
							-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	y after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		-
Medical	□ All	☐ AII			All	☐ All			□ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)				\$1,000.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy	Ц	Ц		\$30.00	_	_				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$60.00						
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$600.00						
Outpatient Current Physician (Curried Consider	✓	V								П
Outpatient Surgery Physician/Surgical Services Drugs	□ All	□ All			All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$50.00	_				i i	
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AK						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004005	7-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	79.04%									
Metal Tier:	Gold									
	NOTE: Service-spec	ific cost-sharing i	s applying for servi	ice(s) with fac/prof	components, ov	erriding outpati	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0273 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_				2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D f't D-		T	T1	2 Dl D 6't F	\!			
	Medical	1 Plan Benefit De Drug	Combined	+	Medical	2 Plan Benefit Drug	Combined			
Deductible (\$)		\$0.00	Combined		Wedical	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$7,90					-				
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	y after deductible
· ·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			☐ All	All			□ All	All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)				\$1,000.00	Ш					Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Casaia list Visit				¢c0.00						П
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00		Ш				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$600.00						
	V	V								
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ All	All			□ All	□ All
Drugs Generics				\$10.00						
Preferred Brand Drugs		<u> </u>		\$50.00						
Non-Preferred Brand Drugs				\$100.00						Ö
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AK						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004005	7-01					
Set a Maximum Number of Days for Charging an IP Copay?	▼		Issuer HIOS ID:	41842						
# Days (1-10):	3									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output # Copays (1-10):										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	80.94%									
Metal Tier:	Gold									
	NOTE: Service-spec	ific cost-sharing i	s applying for servi	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0234 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?	•	Annual Cantui	ihtia.m. Amaamt.		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	ibution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit [Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)	1 /-			-						
			_							
Click Here for Important Instructions		Tie	er 1			Т	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	□ All	□ All	uniciciie	эсрагасс	All	□ All	uniciciii	зералис	□ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)		<u> </u>		\$300.00						
All impatient nospital services (inc. Mn/SOD)	•	<u> </u>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$60.00						
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	>	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
				\$50.00						
Preferred Brand Drugs										
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:	_	1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BQ-AK						
Specialty Rx Coinsurance Maximum:	_	1	Plan HIOS ID:	41842DC004005	7-01					
Set a Maximum Number of Days for Charging an IP Copay?	Ш		Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		1								
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):]								
Output										
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] pe	rcent de minimis va	ariation.						
Actuarial Value:	84.79%									
Metal Tier:										
Additional Notes:										
, additional froces										
Coloniation Times	0.0204 - '									
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier	Gold ▼									
Desired Wetai Hel		1 Plan Benefit De	esign	1	Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined	1	Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$7,90	00.00								
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	or 1			Ti	ier 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	, after deductible
Medical	All	☐ All			☐ All	☐ All			□ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						_
Special merapy										
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	•								
Outpatient Surgery Physician/Surgical Services	✓	✓								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00					0	
Preferred Brand Drugs				\$50.00						
Non-Preferred Brand Drugs			***************************************	\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AK						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004005	7-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation resolve	ed without matchin	ng metal tiers.							
	87.48%									
Metal Tier:	Platinum									
Additional Notar										
Additional Notes:										
Calculation Time:	0.0352 seconds									
Final 2020 AV Calculator	0.000 Seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau	_	Ties	2 Dlan Danafit I	Design			
	Medical	Drug	Combined	_	Medical	2 Plan Benefit I	Combined			
Deductible (\$)	\$2,020.00	\$0.00	Combined		ivicuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$7,90			T		1				
MOOP if Separate (\$)				-						
							-			
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
Madhad	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		☐ All
Medical Securities	☐ AII	☐ All			All	AII			□ All	All
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	<u>v</u>								
All Impatient Hospital Services (Inc. Ivin/300)	•	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Specialist Visit				\$20.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$20.00						
Services										
Imaging (CT/PET Scans, MRIs)				\$20.00						
Speech Therapy				\$20.00						
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization	П	П		\$0.00		П				
Laboratory Outpatient and Professional Services				\$20.00						
X-rays and Diagnostic Imaging				\$20.00						
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	✓	☑								
Drugs	□ All	✓ All			□ All	□ All			□ All	□ All
Generics		<u> </u>	80%							
Preferred Brand Drugs		✓	80%							
Non-Preferred Brand Drugs		V	80%							
Specialty Drugs (i.e. high-cost)		V	96%							
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AL						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	79.61%									
Metal Tier:	Gold									
Additional Notes:										
Calculation Time: Final 2020 AV Calculator	0.0273 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		15	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletii	bution Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit [Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,020.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$7,9	00.00				•				
MOOP if Separate (\$)				-						
			-							
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			☐ All	☐ All			□All	☐ All
Emergency Room Services		✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	✓			ō	Ō				
All imputerit riospitar services (inc. wiriy 500)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Considiat Visit				\$20.00						
Specialist Visit				\$20.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$20.00						
Services										
Imaging (CT/PET Scans, MRIs)				400.00						
Speech Therapy				\$20.00						
				\$20.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$20.00						
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Output energation (e.g., Ambuild for youngery center)						_				
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	✓ All			☐ All	☐ All			□ All	☐ All
Generics		V	80%							
Preferred Brand Drugs		V	80%							
Non-Preferred Brand Drugs		V	80%							
Specialty Drugs (i.e. high-cost)		✓	96%							
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AL						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	35-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	80.87%									
Metal Tier:	Gold									
		re services are not	subject to the ded	uctible and have no	o copav. Anv sei	vice with this co	st-sharing structur	e is covered at	100% by the plan in t	the deductible
Additional Notes:	range.		,						,	
Additional Notes.										
Calculation Time:	0.0273 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			red Network Op				
Apply Inpatient Copay per Day?	i	HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6'4 D-		T	T'	2 Dl D 6't F				
	Medical	1 Plan Benefit De Drug	Combined	+	Medical	2 Plan Benefit Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$7,90					I.				
MOOP if Separate (\$)				-						
						•				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	v after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	☐ All			☐ All	All			□ All	All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)				\$1,000.00	Ш					Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Considiat Visit				¢c0.00						П
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00		Ш				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$60.00						
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$600.00						
	✓	V								
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ All	All			□ All	□ All
Drugs Generics				\$10.00						
Preferred Brand Drugs		<u> </u>		\$50.00						
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:	_		Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AM						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001007	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	3									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	79.04%									
Metal Tier:	Gold									
	NOTE: Service-spec	ific cost-sharing i	s applying for servi	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0273 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		71111001 0011011	bactorry unloane.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
		1 Plan Benefit De		_		2 Plan Benefit D				
Deductible (\$)	\$0.00	Drug \$0.00	Combined	-	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$7,90			•		-				
MOOP (5)		0.00		-						
moor it separate (v)										
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6 1 1 111 1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)				\$1,000.00						
Drimary Caro Vicit to Troat an Injury or Illnoss (ave. Broyenting, and Virgue)				\$30.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services					_					
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy	_	_			_	_				
Preventive Care/Screening/Immunization			4000/	\$0.00						
Laboratory Outpatient and Professional Services X-rays and Diagnostic Imaging			100%	\$60.00						
Skilled Nursing Facility				\$1,000.00	H					
Skilled Notising Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$600.00						
Outpatient Surgery Physician/Surgical Services	✓	✓								
Drugs	☐ AII	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$50.00						
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AM						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001007	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	3									
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	80.94%									
Metal Tier:	Gold									
	NOTE: Service-spec	ific cost-sharing i	s applying for servi	ce(s) with fac/prof	components, ov	erriding outpatie	ent inputs for those	e service(s).		
Additional Notes:										
Calculation Time:	0.0234 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?	•	Annual Cantril	hustian Amazuntu		1st	Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?					•					
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$7,9	00.00								
MOOP if Separate (\$)				-						
,			•				•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1.411
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	/ arter deductible
Medical	□ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				300.00						
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
Speech merapy				220.00						
Conventional and Physical Thoraca				\$30.00						
Occupational and Physical Therapy	П	П		\$0.00	_	_				
Preventive Care/Screening/Immunization										_
Laboratory Outpatient and Professional Services				\$60.00						
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
					_					_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All		*	☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$50.00		_				_
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:	_	1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AM						
Specialty Rx Coinsurance Maximum:	_	-	Plan HIOS ID:	41842DC001007	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Error: Result is out	tsiae of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	84.79%									
Metal Tier:										
Additional Notes:										
Calculation Time:	0.0352 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Wetai Her		1 Plan Benefit De	esign	1	Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined	1	Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$7,90	00.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	or 1			Ti	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
Special merapy										
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
	✓	✓								
Outpatient Surgery Physician/Surgical Services Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs		Ö		\$50.00						
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AM						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010078	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation resolve	ed without matchin	ng metal tiers.							
	87.48%									
Metal Tier:	Platinum									
Additional Notes										
Additional Notes:										
Coloulation Times	0.0353 accord									
Calculation Time: Final 2020 AV Calculator	0.0352 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	1? □	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:		15	t Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	dition Amount.		2nd	d Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)										
						_			T =: 4	
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
20 11 1	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	✓ All			☐ All	☐ All			All	All
Emergency Room Services		Z								
All Inpatient Hospital Services (inc. MH/SUD)		V			Ш					
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		•								
Specialist Visit		V				Ш				
Mental/Behavioral Health and Substance Use Disorder Outpatient		•								
Services					_					
Imaging (CT/PET Scans, MRIs)		V								
Speech Therapy		V								
		✓								
Occupational and Physical Therapy	_									
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services		<u> </u>								
X-rays and Diagnostic Imaging		<u> </u>								
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		✓								
Output in Survey Division / Survival Survival	V	V				П				
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ □ All	All			□ All	All
Drugs	□ All			\$10.00		□ All			□ All	All
Generics Preferred Brand Drugs				\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
3	<u> </u>								V	
Specialty Drugs (i.e. high-cost)	V		Plan Description	\$120.00	Ш	ш			V	
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AN						
Specialty Rx Coinsurance Payments: Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	6 01					
					00-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	81.85%									
Metal Tier:	Gold									
		cific cost-sharing is	applying for servi	ice(s) with fac/prof	components o	verriding outpati	ent inputs for those	e service(s)		
Additional Notes:	2 . 2 . 2 . 7 . c c spc			(=,, pror						
Additional Motes.										
Colordation Times	0.0272 - '									
Calculation Time:	0.0273 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar Comer	oacion, uno anci		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De	1			2 Plan Benefit I				
Dodustiklo (Ć)	\$0.00	Drug \$250.00	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00		-		1				
MOOP if Separate (\$)		00.00		_						
moor in separate (V)							•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	6
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible?
Medical	☐ All	✓ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services		V								
All Inpatient Hospital Services (inc. MH/SUD)		V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓								
Specialist Visit		V								
Mental/Behavioral Health and Substance Use Disorder Outpatient		✓								
Services	L									
Imaging (CT/PET Scans, MRIs)		V								_
Speech Therapy		V								
Occupational and Dhysical Thereny		✓								
Occupational and Physical Therapy Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		✓	100%	ŞU.UU						
X-rays and Diagnostic Imaging		V	100%							
Skilled Nursing Facility		·								H
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AN						
Specialty Rx Coinsurance Maximum:		-	Plan HIOS ID:	41842DC001008	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?		+								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	82.42%									
Metal Tier:										
	NOTE: Service-spe	ecific cost-sharing i	s applying for servi	ice(s) with fac/prof	components, ov	erriding outpati	ent inputs for those	e service(s).		
Additional Notes:										
Calculation Time:	0.0234 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		, amada comer	bactott / title dire.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		L Plan Benefit De		-		2 Plan Benefit I				
Destructible (A)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$1,750.00							
Coinsurance (%, Insurer's Cost Share) MOOP (\$)			100.00%	+						
MOOP (\$) MOOP if Separate (\$)			\$3,000.00	_						
WOOF II Separate (3)										
Click Here for Important Instructions		Tie	er 1			т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible?
Medical	✓ All	All	uniciciie	зерание	All	□ All	uniciciii	эсрагаес	☐ All	□ All
Emergency Room Services	✓			\$250.00		<u> </u>			<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	✓	<u> </u>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	~	V								
Specialist Visit	V	V								
Mental/Behavioral Health and Substance Use Disorder Outpatient		_								
Services	~	✓								
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	V	V								
	V	V								
Occupational and Physical Therapy	1									
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	▽	V								
Skilled Nursing Facility	✓	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
	V	✓								
Outpatient Surgery Physician/Surgical Services	✓ All				□ All	□ All			□ □ All	
Drugs Generics	✓ All	□ All		\$10.00	□ All				V All	All
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V	ä		\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AO						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010006	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status/Error Messages:	Calculation Success	iol.								
Actuarial Value:	81.35%	ui.								
Metal Tier:	Gold									
Additional Notes:										
, additional Hotes.										
Calculation Time:	0.043 seconds									
Final 2020 AV Calculator	5.545 Seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s		ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	i? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		r 1 Plan Benefit De	sian		Tion	2 Plan Benefit [Docian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		Wicalcar	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00				•				
MOOP if Separate (\$)				-			[
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	• • •	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All		4000.00	All	All			□ All	☐ All
Emergency Room Services				\$200.00						
All Inpatient Hospital Services (inc. MH/SUD)		Ш								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$10.00						
Specialist Visit				\$20.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										·····
Services				\$20.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$10.00						
				\$10.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services										
X-rays and Diagnostic Imaging Skilled Nursing Facility		<u> </u>								
Skilled Nulsing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$40.00		Ш				
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-AQ 41842DC001007	4.01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	4-01					
# Days (1-10):			issuci illos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):]								
Output										
Calculate	Coloulation Corre	oofl								
Status/Error Messages: Actuarial Value:	Calculation Succes 88.77%	ssiui.								
Metal Tier:	88.77% Platinum									
medi nen		ecific cost-sharing is	s applying for servi	ice(s) with fac/prof	components. ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:	2 . 2 . 2 spc			,=,		o ocepation				
Calculation Time:	0.0273 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:		Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		r 1 Plan Benefit De	alau	_	Tion	2 Dlan Danafit F	Nacion .			
	Medical	Drug	Combined	-	Medical	2 Plan Benefit I	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)				-						
							_		•	
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Bandton!	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical	□ All	□ All		¢200.00	All				All	AII
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)				\$200.00						
All impatient hospital services (inc. Min/30D)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$10.00						
Specialist Visit				\$20.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient					_				_	
Services				\$20.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$10.00						
				\$10.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services										
X-rays and Diagnostic Imaging										
Skilled Nursing Facility					_					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$40.00						
Options for Additional Benefit Design Limits:		,	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AQ						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010074	4-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	Ш		Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	93.72%									
Metal Tier:										
A University of the control of the c										
Additional Notes:										
Coloriation Times	0.0353 - '									
Calculation Time: Final 2020 AV Calculator	0.0352 seconds									
rinai 2020 AV Calculatui										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	· 🗆		HSA/HRA Option:	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		101 0 010		_	_	201 0 611				
		1 Plan Benefit De				2 Plan Benefit I				
Deductible (\$	Medical \$0.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)				-		1				
MOOP if Separate (\$)				-						
						'	•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Toma of Donofit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Consu annlies on	ly after deductible?
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies on	y after deductible:
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services		V								
All Inpatient Hospital Services (inc. MH/SUD)		✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
	_									_
Specialist Visit				\$20.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$20.00						
Services Imaging (CT/PET Scans, MRIs)										_
Speech Therapy				\$20.00						
Speech Therapy				·····						
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization				\$0.00						<u> </u>
Laboratory Outpatient and Professional Services				\$20.00						
X-rays and Diagnostic Imaging				\$20.00						
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
O to the Common Physician I Commission	✓	V								П
Outpatient Surgery Physician/Surgical Services Drugs	□ All	✓ All			□ □ All	□ All			□ All	□ All
Generics		✓ All	80%							
Preferred Brand Drugs		✓	80%							
Non-Preferred Brand Drugs		✓	80%		Ō					
Specialty Drugs (i.e. high-cost)		V	96%							
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?	· 🗆		Name:	BQ-AR						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	37-01					
Set a Maximum Number of Days for Charging an IP Copay?	· 🗆		Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output # Copays (1-10).										
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	86.11%									
Metal Tier:	Platinum									
	NOTE: Service-spe	cific cost-sharing is	s applying for servi	ice(s) with fac/prof	components, ov	erriding outpati	ent inputs for those	e service(s).		
Additional Notes:										
Calculation Time:	0.0234 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Dlaw Bawafit Da	alau	_	Tion	2 Plan Benefit I	Dasies			
	Medical	1 Plan Benefit De Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	1	100.00%								
MOOP (\$)				T		1				
MOOP if Separate (\$)				-						
			-				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	v after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services		<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)		V				Ō				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Constallation (Constallation)				ć20.00		П				
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient		Ш		\$20.00						
Services				\$20.00						
Imaging (CT/PET Scans, MRIs)		V								
Speech Therapy				\$20.00						
										-
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		v	100%							
X-rays and Diagnostic Imaging				\$20.00						
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
					_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ AII	✓ All	9994		☐ All	☐ All			□ All	☐ All
Generics Professed Proped Proped		V	80% 80%							
Preferred Brand Drugs Non-Preferred Brand Drugs		V	80%							
Specialty Drugs (i.e. high-cost)		✓	96%							
Options for Additional Benefit Design Limits:			Plan Description:	•						
Set a Maximum on Specialty Rx Coinsurance Payments?	· 🗆		Name:	BQ-AR						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	7-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	:									
Begin Primary Care Cost-Sharing After a Set Number of Visits?	. 🗆									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	ful								
Actuarial Value:	87.29%	iui.								
Metal Tier:	Platinum									
		ific cost-sharing is	applying for servi	ce(s) with fac/prof	components. ov	erriding outpati	ent inputs for those	service(s).		
Additional Notes:			, 0 - 7	., , p						
Calculation Time:	0.0273 seconds									

User Inputs for Plan Parameters								1		
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	n? 🗆	Tiere	d Network Plan?	•			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1s	t Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	d Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,000.00	\$250.00			\$1,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%			80.00%	100.00%				
MOOP (\$)	\$7,9	00.00			\$7,9	00.00				
MOOP if Separate (\$)				_				'		
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	. Caman if	Subject to	Subject to	Coinsurance, if	Caman if	TIEL I	Hei Z
Type of Benefit	Deductible?	Coinsurance?	different	Copay, if separate	Deductible?	Coinsurance?	different	Copay, if separate	Copay applies only	after deductible?
Medical		□ All	amerent	separate	□ All	All	dirierent	separate	□ All	☐ All
	☑ All	✓ All	F00/				F.00/			
Emergency Room Services	V		50%		V	V	50%			
All Inpatient Hospital Services (inc. MH/SUD)		V			V					
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			•	100%			
Specialist Visit				\$55.72				\$80.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient				······································						
Services		~	100%			✓	100%			
Imaging (CT/PET Scans, MRIs)				\$500.00				\$500.00		
Speech Therapy		✓			_	☑				
					†					
Occupational and Physical Therapy	✓	V			✓	V				
Preventive Care/Screening/Immunization		П		\$0.00				\$0.00		
Laboratory Outpatient and Professional Services				\$40.00				\$40.00		
X-rays and Diagnostic Imaging				\$40.00				\$40.00		Ö
Skilled Nursing Facility	V	<u> </u>		540.00	✓			340.00		
Skilled (Vd) Sing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V			V	V				
Outpatient Surgery Physician/Surgical Services	V	V			V	V				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	V			\$40.00	V			\$40.00	✓	✓
Non-Preferred Brand Drugs	V			\$75.00	V			\$75.00	✓	✓
Specialty Drugs (i.e. high-cost)	V			\$120.00	V			\$120.00	✓	✓
Options for Additional Benefit Design Limits:			Plan Description	1:	•				•	
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-AW						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	79.67%									
Metal Tier:	Gold									
		re services are not	subject to the ded	luctible and have no	copay. Any sei	vice with this co	st-sharing structur	re is covered at	100% by the plan in t	he deductible
Additional Notes:	range.		,				. 32236		, p	
Additional Notes.	. 3									
- L L :: -										
Calculation Time:	0.0742 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	~			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bution Amount.		2nd	Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,000.00	\$250.00			\$1,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%			80.00%	100.00%				
MOOP (\$)	\$7,9	00.00			\$7,9	00.00				
MOOP if Separate (\$)				-						
			 				_			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copuy applies only	arter academbie
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	•	✓	50%		V	•	50%			
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓			✓	✓				
Deiman, Cara Visit to Tract on Injury or Illness (over Draventine and Visus)			100%				100%			
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		>	100%			✓	100%			
Specialist Visit				\$55.72				\$80.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient			100%				100%			
Services		✓	100%			V	100%			
Imaging (CT/PET Scans, MRIs)				\$500.00				\$500.00		
Speech Therapy	v	V			V	v				
	✓	V			V	V				
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00				\$0.00		
Laboratory Outpatient and Professional Services		V	100%			V	100%			
X-rays and Diagnostic Imaging				\$40.00				\$40.00		
Skilled Nursing Facility	V	✓			✓	V				
Outpotiont Facility Fac (a.g. Ambulaton Currons Conton)	V	V			V	✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V			V	✓				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	V			\$40.00	V			\$40.00	V	✓
Non-Preferred Brand Drugs	V			\$75.00	V			\$75.00	V	✓
Specialty Drugs (i.e. high-cost)	V			\$120.00	>			\$120.00	✓	✓
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AW						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	81.37%									
Metal Tier:	Gold									
	NOTE: One or mo	re services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structur	e is covered at	100% by the plan in t	he deductible
Additional Notes:	range.									
Calculation Time:	0.0938 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	V			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		15	t Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	batton Amount.		2nd	d Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				7						
		r 1 Plan Benefit De	1	_		2 Plan Benefit D				
44	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00			\$1,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)		100.00%		+	80.00%	100.00%				
MOOP (\$) MOOP if Separate (\$)		00.00		1	\$7,9	00.00				
MOOP If Separate (5)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			□ All	☐ All			□ All	☐ All
Emergency Room Services	V	V	50%		✓	✓	50%			
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓			✓	✓				
**************************************									_	_
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			✓	100%			
Specialist Visit				\$55.72				\$80.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient		_	100%			_	100%			_
Services		V	100%			✓	100%			
Imaging (CT/PET Scans, MRIs)				\$500.00				\$500.00		
Speech Therapy	V	V			V	V				
	V	✓			✓	✓				
Occupational and Physical Therapy									1	-
Preventive Care/Screening/Immunization				\$0.00				\$0.00		
Laboratory Outpatient and Professional Services				\$40.00				\$40.00		
X-rays and Diagnostic Imaging				\$40.00				\$40.00		
Skilled Nursing Facility	V	V			V	V				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•			✓	✓				
	V					✓				
Outpatient Surgery Physician/Surgical Services		☑ □ All			·	□All				
Drugs	□All			45.00	□ All			45.00	□ All	
Generics Defended Provide Prov				\$5.00				\$5.00 \$40.00		
Preferred Brand Drugs Non-Preferred Brand Drugs	V			\$40.00 \$75.00	V			\$75.00	<u> </u>	<u>v</u>
Specialty Drugs (i.e. high-cost)	V			\$120.00	V			\$120.00	<u> </u>	V
Options for Additional Benefit Design Limits:			Plan Description:	-				J120.00		
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BQ-AX						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010082	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):]								
Output										
Calculate										
Status/Error Messages:	Calculation Succes	sstul.								
Actuarial Value:	79.67%									
Metal Tier:	Gold				_					
		re services are not	subject to the dedu	actible and have no	copay. Any sei	rvice with this co	st-sharing structure	e is covered at	100% by the plan in	tne deductible
Additional Notes:	range.									
Calculation Time:	0.0625 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	V			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				-						
		r 1 Plan Benefit De	1			2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00			\$1,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)		100.00%		-	80.00%	100.00%				
MOOP (\$)		00.00			\$7,9	00.00				
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	or 1			Ti	er 2		Tier 1	Tier 2
Click Here for important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Heir	TICI Z
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	□ All	□ All	unierent	separate	□ All	□ All	uniterent	separate	□ All	□ All
Emergency Room Services	V	<u> </u>	50%		<u> </u>	✓	50%			
All Inpatient Hospital Services (inc. MH/SUD)	v	V	3070		✓	✓	30/0			
An impatient nospital services (inc. Will/300)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			~	100%			
Specialist Visit				\$55.72				\$80.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient	†			755.72				900.00		
Services		✓	100%			~	100%			
Imaging (CT/PET Scans, MRIs)				\$500.00				\$500.00		
Speech Therapy					_ _	✓				
						~				
Occupational and Physical Therapy	✓	✓			✓	✓				
Preventive Care/Screening/Immunization		П		\$0.00				\$0.00		
Laboratory Outpatient and Professional Services		<u> </u>	100%			v	100%			
X-rays and Diagnostic Imaging				\$40.00				\$40.00		
Skilled Nursing Facility	✓	✓		·	✓	✓				
	V	✓				✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		⊻			V	⊻				
Outpatient Surgery Physician/Surgical Services	✓	✓			V	V				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	✓			\$40.00	V			\$40.00	V	V
Non-Preferred Brand Drugs	✓			\$75.00	V			\$75.00	V	V
Specialty Drugs (i.e. high-cost)	V			\$120.00	V			\$120.00	V	✓
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AX						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010082	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):]								
Output										
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	81.37%									
Metal Tier:	Gold									
		re services are not	subject to the dedu	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	he deductible
Additional Notes:	range.									
Calculation Time:	0.0625 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network O _l	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	? •			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:	: 47%			
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	oution Amount.		2nd	Tier Utilization:	: 53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00			\$2,750.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%			80.00%	100.00%				
MOOP (\$)	\$7,9	00.00			\$7,9	00.00				
MOOP if Separate (\$)										
Cliab Hara facility and back to broad and			4						Ti 4	T 2
Click Here for Important Instructions		Tie		- "			ier 2	- "	Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only	after deductible
Medical	☐ All	□ All	unierent	зерагате	□ All	□ All	uniterent	зерагате	☐ All	☐ All
Emergency Room Services	<u> </u>	<u> </u>	50%		▽	✓	50%			
All Inpatient Hospital Services (inc. MH/SUD)	V	V	30/0		V	<u> </u>	30/0			
all ripatient nospital services (inc. Will) 300)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			✓	100%			
Specialist Visit				\$69.65				\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient				203.03				\$100.00		
Services		✓	100%			•	100%			
Imaging (CT/PET Scans, MRIs)	V	V			V	V				
Speech Therapy	v	<u> </u>			v	☑				
, , , , , , , , , , , , , , , , , , ,										
Occupational and Physical Therapy	✓	V			✓	✓				
Preventive Care/Screening/Immunization				\$0.00				\$0.00		
Laboratory Outpatient and Professional Services		☑			v	☑		T-11-1		
X-rays and Diagnostic Imaging	✓	✓			<u> </u>	✓				
Skilled Nursing Facility	✓	✓			✓	✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V			✓	V				
Outpatient Surgery Physician/Surgical Services	V	V			V	✓				
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	✓			\$40.00	V			\$40.00	V	✓
Non-Preferred Brand Drugs	✓			\$75.00	V			\$75.00	V	✓
Specialty Drugs (i.e. high-cost)	✓			\$120.00	V			\$120.00	✓	✓
Options for Additional Benefit Design Limits:			Plan Description:	:	•				•	
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-AY						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	88-01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П	1								
Copays?	_									
# Copays (1-10):										
Output		•								
Calculate										
	Error: Result is ou	tside of [-4, +2] per	cent de minimis va	ariation.						
	75.86%	. , ,,,,,,								
Metal Tier:										
	NOTE: One or mo	re services are not	subject to the dedi	uctible and have no	o copav. Anv sei	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
		ice-visit-specific co								
nuultional Notes.		speeme eo	o o							
Calculation Time:	0.0664 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	· •			
Apply Skilled Nursing Facility Copay per Day?					1st	Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
	Tier !	L Plan Benefit De	esign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00			\$2,750.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%			80.00%	100.00%				
MOOP (\$)	\$7,900	0.00			\$7.9	00.00				
MOOP if Separate (\$)				-						
							•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductibl
Medical	All	□ All	unicient	Separate	□ All	□ All	uniciciit	Беринис	☐ All	☐ All
Emergency Room Services	☑	<u> </u>	50%		✓	<u> </u>	50%			
All Inpatient Hospital Services (inc. MH/SUD)	V	✓ .			V	V				
All ripatient nospital services (inc. ivi1/300)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		~	100%			~	100%			
Constitution of the second				¢co ce				Ć100.00		
Specialist Visit		Ш		\$69.65		Ш		\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient		✓	100%			✓	100%			
Services		- ✓			✓	✓				
Imaging (CT/PET Scans, MRIs)						~~~~~~				
Speech Therapy	V	V			V	V				
	✓	✓			✓	✓				
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00	<u> </u>			\$0.00		
Laboratory Outpatient and Professional Services		V	100%			<u>v</u>	100%			
X-rays and Diagnostic Imaging	V	V			✓	V				
Skilled Nursing Facility	V	V			V	V				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	•			V	•				
Outpatient Surgery Physician/Surgical Services	V	✓			V	✓				
Drugs	— □ All	— □ All			□ All	— □ All			□ All	□ All
Generics				\$5.00				\$5.00	0	
Preferred Brand Drugs	v			\$40.00	✓			\$40.00	· ·	☑
Non-Preferred Brand Drugs	<u> </u>			\$75.00	✓			\$75.00	· ·	☑
Specialty Drugs (i.e. high-cost)	V			\$120.00	☑			\$120.00	<u> </u>	V
Options for Additional Benefit Design Limits:			Plan Description:					Ţ120.00		
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AY						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	R_01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	5 01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Success	S. I								
. 9	Calculation Successf	ui.								
	77.13%									
	Gold		audiant to the deal						1000/ hu tha ala ! t	- امانغم بام ماه مما
	NOTE: One or more		-			vice with this co	ist-silaring structure	s is covered at	100% by the plan in t	ne deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-snaring is applyi	rig to x-rays in offic	e settings.					
Calculation Time:	0.0664 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	•			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bution Amount.		2nc	Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tier :	L Plan Benefit De	esign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$5,000.00	\$250.00			\$5,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%			70.00%	100.00%				
MOOP (\$)	\$8,150	0.00			\$8,1	50.00				
MOOP if Separate (\$)				-						
			_				-			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Tune of Renefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductib
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies only	arter deductib
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	•	50%		V	V	50%			
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓			V	✓				
	_	_				_			_	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		\checkmark	100%			✓	100%			
Specialist Visit				\$69.65				\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services		~	100%			✓	100%			
Imaging (CT/PET Scans, MRIs)	V	V			v	V				
Speech Therapy	<u> </u>	v			v	☑				
					<u> </u>					
Occupational and Physical Therapy	V	V			V	✓				
Preventive Care/Screening/Immunization				\$0.00				\$0.00		
Laboratory Outpatient and Professional Services				30.00	v	<u> </u>		30.00		
X-rays and Diagnostic Imaging	V	V			V	₹				
Skilled Nursing Facility	<u> </u>	✓			✓	✓				
Skilled Nursing Facility					***************************************					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•			✓	✓				
Outpatient Surgery Physician/Surgical Services	V	V			V	V				
Drugs	☐ All	☐ All			□AII	☐ All			☐ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	V			\$40.00	V			\$40.00	V	V
Non-Preferred Brand Drugs	<u> </u>			\$75.00	<u> </u>			\$75.00		
Specialty Drugs (i.e. high-cost)	✓			\$120.00				\$120.00		✓
Options for Additional Benefit Design Limits:			Plan Description:					7		
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-AZ						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004006	5-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842						
# Days (1-10):			1000001111001121	12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Successi	ful.								
	71.76%									
	Silver									
		services are not	subject to the dod	ictible and have no	CODAY ADVICE	vice with this co	st-sharing structure	is covered at	100% by the plan in t	he deductible
	range. NOTE: Office		-			AICE MAICH FILIS CO.	ac anaring structure	. 13 covereu at	10070 by tile plair III t	ne deductible
Additional Notes:	range. NOTE. Office	=-visit=specific co	oc-silaring is applyi	ing to x-rays in OTTIC	ce settings.					
Calculation Time:	0.0586 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O _l	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?	? •			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1s	t Tier Utilization:	: 47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	d Tier Utilization:	: 53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$5,000.00	\$250.00			\$5,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%		_	70.00%	100.00%				
MOOP (\$)	\$8,1	50.00			\$8,1	50.00				
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All		· ·	☐ All	☐ All			□ All	☐ All
Emergency Room Services	✓	V	50%		✓	V	50%			
All Inpatient Hospital Services (inc. MH/SUD)	V	V			V	V				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		V	100%			~	100%			
Specialist Visit				\$69.65				\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services		~	100%			~	100%			
Imaging (CT/PET Scans, MRIs)	V	V			V	V				
Speech Therapy	✓	V			V	V				
	V	V			v	V				
Occupational and Physical Therapy									_	_
Preventive Care/Screening/Immunization				\$0.00				\$0.00		
Laboratory Outpatient and Professional Services		<u> </u>	100%			<u> </u>	100%			
X-rays and Diagnostic Imaging	V	V			V	✓				
Skilled Nursing Facility	V	✓			V	V				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	✓			✓	•				
Outpatient Surgery Physician/Surgical Services	V	V			V	V				
Drugs	□ All	☐ All			□AII	☐ All			□ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	V			\$40.00	✓			\$40.00	V	V
Non-Preferred Brand Drugs	✓			\$75.00	✓			\$75.00	✓	V
Specialty Drugs (i.e. high-cost)	✓			\$120.00	V			\$120.00	V	V
Options for Additional Benefit Design Limits:			Plan Description	:	•				•	
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-AZ						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):]								
Output Calculate										
	Error: Result is ou	tside of [-4, +2] per	cent de minimis va	ariation.						
	73.35%	. , ,,,,,,,								
Metal Tier:										
	NOTE: One or mo	re services are not	subject to the ded	uctible and have no	copay. Any sei	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
			-	ing to x-rays in offic			-			
		•		•	-					
Calculation Time:	0.0703 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?	✓			
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
		1 Plan Benefit De	1			2 Plan Benefit D				
5 J. 111 (A)	Medical	Drug	Combined	_	Medical	Drug	Combined			
Deductible (\$)	\$5,000.00	\$250.00			\$5,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%		-	70.00%	100.00%				
MOOP (\$)	\$8,15	0.00			\$8,1	50.00				
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	r 1			Ti	er 2		Tier 1	Tier 2
CHECK TIETE TOT HISPOTANTE HISE ACCIONS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	All	All	umerent	зериние	All	□ All	uniciciii	эсрание	☐ All	☐ All
Emergency Room Services	✓	<u> </u>	50%		✓	<u> </u>	50%			
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓			✓	✓				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			✓	100%			
Specialist Visit				\$69.65				\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_	4000/	······································	_	_	4000/		_	_
Services		V	100%			~	100%			
Imaging (CT/PET Scans, MRIs)	V	V			V	V				
Speech Therapy	V	V			V	v				
	✓	V			V	v				
Occupational and Physical Therapy									П	
Preventive Care/Screening/Immunization				\$0.00				\$0.00		
Laboratory Outpatient and Professional Services	✓	V			V	V				
X-rays and Diagnostic Imaging	V	✓			V	V				
Skilled Nursing Facility	V	✓			V	✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓			✓	V				
Outpatient Surgery Physician/Surgical Services	V	✓			V	✓				
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	✓			\$40.00	V			\$40.00	V	V
Non-Preferred Brand Drugs	✓			\$75.00	V			\$75.00	V	V
Specialty Drugs (i.e. high-cost)	V			\$120.00	~			\$120.00	~	~
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A2						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010089	9-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Success	ful.								
	71.76%									
	Silver									
	NOTE: One or more	services are not	subject to the dedu	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in t	he deductible
Additional Notes:	range. NOTE: Offic	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0625 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆	Tiere	d Network Plan?	· •			
Apply Skilled Nursing Facility Copay per Day?		Annual Cantuil	autian Amazunt.		1st	Tier Utilization:	47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contril	oution Amount:		2nd	Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$5,000.00	\$250.00			\$5,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%			70.00%	100.00%				
MOOP (\$)	\$8,1	50.00			\$8,1	50.00				
MOOP if Separate (\$)										
·										
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
· ·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	✓	V	50%		V	V	50%			
All Inpatient Hospital Services (inc. MH/SUD)	V	V			V	V				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		•	100%			✓	100%			
			10070				20070			
Specialist Visit				\$69.65				\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient		~	100%			~	100%			
Services										
maging (CT/PET Scans, MRIs)	<u> </u>	<u> </u>			<u> </u>	<u>v</u>				
Speech Therapy	V	V			V	V				
	✓	•			✓	✓				
Occupational and Physical Therapy				40.00				ćo 00		
Preventive Care/Screening/Immunization			4000/	\$0.00			4000/	\$0.00		
Laboratory Outpatient and Professional Services		V	100%			V	100%			
X-rays and Diagnostic Imaging	<u> </u>	<u> </u>			<u>v</u>	✓				
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓			✓	✓				
Outpatient Surgery Physician/Surgical Services	V	V			V	✓			 	
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	V			\$40.00	<u> </u>			\$40.00	V	
Non-Preferred Brand Drugs	V			\$75.00	V			\$75.00	V	V
	<u> </u>				V				<u> </u>	
Specialty Drugs (i.e. high-cost)			Dian Danishton	\$120.00				\$120.00		~
Options for Additional Benefit Design Limits:		1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A2						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001008	9-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_	1								
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output		1								
Calculate										
	Error: Result is our	tside of [-4, +2] per	cent de minimis va	riation						
· · · · · · · · · · · · · · · · · · ·	73.35%	c or [4, +2] per	cent de minimis Vd							
Metal Tier:	, 3.33/0									
	NOTE: One or mo	re centices are not	subject to the dad	uctible and have no	a consu. Any co	vice with this so	ct-charing ctructure	a is covered at	100% by the plan in t	he deductible
						vice with this CO	oc-oriannig ou ucture	e is covered at	100% by the plan in t	ine deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	st-stiditing is applyl	ing to x-rays in OTTIC	ce settings.					
Calculation Time:	0.0625 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		A C	h		1st	: Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contril	bution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
Desired Metal Fiel		1 Plan Benefit De	cian	T	Tior	2 Plan Benefit D	ocian			
	Medical	Drug	Combined	1	Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		Wieulcai	Diug	Combined			
***		•								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)										
			_			_	_			
Click Here for Important Instructions	Subject to	Tie Subject to	Coinsurance, if	Copay, if	Subject to		coinsurance, if	Copay, if	Tier 1	Tier 2
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	□ All	□ All	unierent	separate	All	All	unierent	зерагате	□ All	□ All
	_			4250.00						
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V			Ī					
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
					_					
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services				730.00						
Imaging (CT/PET Scans, MRIs)	V	✓								
Speech Therapy				\$15.00						
				4		П				
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization		П		\$0.00		П				
Laboratory Outpatient and Professional Services				\$30.00	_					
X-rays and Diagnostic Imaging				\$30.00	Ē					
	✓	✓		\$30.00						
Skilled Nursing Facility	V	V							Ш	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
					_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:	•		Plan Description:		•					
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-A3						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001006	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0 01					
# Days (1-10):			issuci ilios ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
,										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	itul.								
Actuarial Value:	90.12%									
Metal Tier:	Platinum									
Additional Notes:										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator	2.2.05 5000.105									
Tillal Eded Av Cultulator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	oyer Contribution	? 🗆	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 mildar correin	outron, anount		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4.51 5 61.5			_					
		r 1 Plan Benefit De				2 Plan Benefit I				
Deductible (\$)	Medical \$250.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-		L				
MOOP if Separate (\$)		00.00		-						
moor in separate (\$)							•			
Click Here for Important Instructions		Tie	r1			Т	ier 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	. 6
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	itter deductible:
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	✓	✓								
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy				\$15.00	_	_				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	V	~								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•								
Outpatient Surgery Physician/Surgical Services	✓	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:	_	1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A3						
Specialty Rx Coinsurance Maximum:		+	Plan HIOS ID:	41842DC0010060	6-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	+								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output Calculate		_								
Status/Error Messages:	Calculation Succes	ssful								
Actuarial Value:	91.92%									
Metal Tier:	Platinum									
		re services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in th	e deductible
Additional Notes:	range.		,		.,.,, 50.				,	
, wastones (to cos	3 -									
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau.	_	Ties	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivicuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)										
MOOP if Separate (\$)				_						
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies on	ly after deductible?
••	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ AII	All		<u>.</u>	☐ All	☐ All			☐ All	All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V			Ш	Ш				Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	✓	61%	\$250.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V	40%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name: Plan HIOS ID:	BQ-A3_POST_ 41842DC001006	C 01					
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842 41842	0-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	88.74%									
Metal Tier:	Platinum	ific cost sharis - '	c applying for ac-	ico(c) with foo /	components -	orriding auto-t	ant innute facth	conjects)		
Additional National	NOTE: Service-spec	inc cost-snaring i	s applying for servi	ice(s) with tac/prof	components, ov	rei riuirig outpati	ent inputs for those	: service(s).		
Additional Notes:										
Calculation Times	0.0204 - 1									
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		, unidar correr	oution / uniounit		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
		1 Plan Benefit De	1			2 Plan Benefit D				
Deductible (\$)	Medical \$250.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)				-		L				
MOOP if Separate (\$)		5.00		-						
			•			-				
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
- (5 %)	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	6	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy				\$15.00						
Occupational and Blowled Theorem				\$15.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		✓	100%	\$0.00						
X-rays and Diagnostic Imaging			100%	\$30.00						H
Skilled Nursing Facility	☑	✓		\$30.00	H					
	V	☑	400/	¢250.00	_					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			40%	\$250.00						
Outpatient Surgery Physician/Surgical Services	v	V								
Drugs	□ All	□ All		4	All	☐ All			All	□ All
Generics Purfaced Parad Parad				\$10.00						
Preferred Brand Drugs				\$40.00 \$75.00						
Non-Preferred Brand Drugs Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-A3 POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010066	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	89.96%									
Metal Tier:	Platinum									
		services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in t	the deductible
Additional Notes:	range. NOTE: Servi		-				-			
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?					1st	: Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
besited Wetal Her		1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		Wedical	Diug	Combined			

Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		-						
MOOP (\$)		0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	ur 1			Tie	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to		Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	□ All	☐ All			□ All	□ All			□ All	□ All
Emergency Room Services				\$250.00						
<u> </u>	V	✓		\$230.00						
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>	<u> </u>							Ш	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Considiat Visit				¢20.00						
Specialist Visit	Ш	Ш		\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	v	61%	\$250.00						
Speech Therapy				\$15.00						
				\$15.00		П				
Occupational and Physical Therapy				\$15.00	_	_				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	✓	<u> </u>		,						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	□ All	☐ All			□ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Diam Danadation							
			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A3_POST_						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001006	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	89.73%									
Metal Tier:	Platinum									
	-									
Additional Notas										
Additional Notes:										
Calculation Time:	0.043 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 mildar correin	oacion, uno anci		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		r 1 Plan Benefit De		_		2 Plan Benefit I				
Deductible (\$)	Medical \$250.00	Drug \$0.00	Combined	_	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-						
MOOP if Separate (\$)		00.00		_						
Moor in separate (9)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	- 6
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	ifter deductible:
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy				\$13.00	_	_				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	V	~								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A3_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	5-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	Ш		Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		+								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П	1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	91.34%									
Metal Tier:	Platinum									
		re services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in th	e deductible
Additional Notes:	range.									
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4.01 0 61.0			_					
		1 Plan Benefit De	1			2 Plan Benefit I				
Deductible (\$)	Medical \$1,750.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,50			-						
MOOP if Separate (\$)	30,30	0.00		-						
Woor in Separate (7)							•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓			Ī	Ö				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Primary Care visit to Treat an injury of limess (exc. Preventive, and x-rays)				\$25.00	_					_
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services				750.00	_					_
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$25.00						
				\$25.00						
Occupational and Physical Therapy	_	_		A0 00	_	_				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	✓✓								
X-rays and Diagnostic Imaging Skilled Nursing Facility	V	✓								
Skilled Nulsing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	All	□ All			All	— — — — — — — — — — — — — — — — — — —			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A5						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Error: Result is outs	side of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	83.47%									
Metal Tier:										
	NOTE: Office-visit-	specific cost-shari	ing is applying to x-	rays in office setti	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,750.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,5	00.00				•				
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	☐ All	□ All
Emergency Room Services	□ All	✓ All	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V	50%	\$230.00						
				4						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services	L			\$50.00	_					
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization		П		\$0.00						
Laboratory Outpatient and Professional Services		<u> </u>	100%	30.00	_					
X-rays and Diagnostic Imaging	✓	✓	20070							
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name:	BQ-A5	г 01					
Set a Maximum Number of Days for Charging an IP Copay?		-	Plan HIOS ID: Issuer HIOS ID:	41842DC0040045 41842	5-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	1								
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Forman Daniella'		and the second of the second							
Status/Error Messages: Actuarial Value:	Error: Result is out 84.32%	tside of [-4, +2] per	cent ae minimis va	ariation.						
Metal Tier:	U4.32/0									
meta, nen	NOTE: One or mor	re services are not	subject to the ded	uctible and have no	copav. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:			-	ing to x-rays in office						300000000
, additional Hotes.	J2.2.3		3	J	0					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	5	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau	1	Tion	2 Plan Benefit D	a a i a u			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,750.00	\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,50					-				
MOOP if Separate (\$)				-						
			_				•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	<u>~</u>	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
				A=0.00	_					□
Specialist Visit		Ш		\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$50.00						
Imaging (CT/PET Scans, MRIs)	V	V	63%	\$250.00						
Speech Therapy			0370	\$25.00						
Special merapy										
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	>	V								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•	42%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description Name:							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	BQ-A5_POST_ 41842DC004004	E 01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	5-01					
# Days (1-10):			133461 11103 15.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	0.1.1.1									
	Calculation Success	stul.								
	79.13% Gold									
Metal Tier:		enacific cost-chari	na is applying to v	rave in office sottin	oge NOTE: Son	ica-specific cost	charing is applying	for service(s)	with fac/prof compo	ants overriding
Additional Nation	outpatient inputs for	•		rays in office settir	igs. NUTE: SERV	ice-specific cost-	silarifig is applying	ioi service(s)	with rac/prof compo	ients, overriding
Additional Notes:	outpatient inputs it	or those service(s)	•							
Calculation Time:	0.0352 seconds									
Calculation Hille.	U.U332 SECUTIUS									

User Inputs for Plan Parameters	-									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		15	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?							<u>.</u>			
Desired Metal Tier	Gold ▼									
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,750.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,50	0.00								
MOOP if Separate (\$)										
			 				-			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	All			☐ All	☐ All			□ All	All
Emergency Room Services	Z	<u> </u>	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
					_					
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services	L				_					
Imaging (CT/PET Scans, MRIs)	V	V	63%	\$250.00						
Speech Therapy				\$25.00						
				\$25.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	✓	~								
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	42%	\$250.00						
			1270	Ų230.00		_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A5_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	15-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?	•									
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	stul.								
Actuarial Value:	80.45%									
Metal Tier:	Gold									
			-				_		100% by the plan in t	
Additional Notes:				ing to x-rays in offi	ice settings. NO	ΓE: Service-specif	ic cost-sharing is a	applying for ser	vice(s) with fac/prof	components,
	overriding outpatie	ent inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6't D.		П	T'	2 Dl D 6'4 D	No1			
	Medical	r 1 Plan Benefit De	1		Medical	2 Plan Benefit D				
Deductible (\$)		Drug \$0.00	Combined		iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00		-		1				
MOOP if Separate (\$)				-						
,			_			•	•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	v after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	<u> </u>	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
				A=0.00		П				
Specialist Visit	Ш			\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$50.00						
Imaging (CT/PET Scans, MRIs)	V	V	63%	\$250.00						
Speech Therapy			0070	\$25.00						
										_
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V			П					
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All		Ć40.00	□ All	☐ All			□ All	☐ All
Generics Preferred Brand Drugs				\$10.00 \$40.00						
Non-Preferred Brand Drugs				\$40.00						
Specialty Drugs (i.e. high-cost)				\$120.00						Ö
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-A5_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):]								
Output Calculate										
Calculate Status/Error Messages:	Error: Result is out	tside of [-4 ±2] no	reent de minimis va	riation						
Actuarial Value:	82.64%	Iside 01 [-4, +2] per	rcent de minimis va	mation.						
Metal Tier:	02.04/0									
The control of the co	NOTE: Office-visit	-specific cost-shari	ing is applying to x-	ravs in office setting	ngs.					
Additional Notes:		.,	0FF-16 to v	. ,	<u>.</u>					
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		/ umadi comen			2nd	l Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		er 1 Plan Benefit De	1			2 Plan Benefit I				
Deductible (\$)	\$1,750.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-		L				
MOOP if Separate (\$)		1		-						
			•			-				
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Town of Donnells	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	after dedtible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V	V	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	7	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
					_					
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services		✓	63%	\$250.00						
Imaging (CT/PET Scans, MRIs)			63%	\$25.00						
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		☑	100%	70.00						
X-rays and Diagnostic Imaging										
Skilled Nursing Facility	✓	✓								
Output in the little for the Angle Later Course Court of	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)			Dian Danishina	\$120.00		Ш				
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		٦	Plan Description Name:	BQ-A5_POST_						
Specialty Rx Coinsurance Payments: Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	5-01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	5 01					
# Days (1-10):				120.12						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	5 5 h:									
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value: Metal Tier:	83.49%									
IVICLAL LICL.	NOTE: One or mo	re services are not	subject to the ded	uctible and have n	n conav. Anv se	vice with this co	ct-charing ctructure	is covered at	100% by the plan in t	he deductible
Additional Notes:		ice-visit-specific co				vice with this to	or orienting or acture	. 13 COVERED AL	100/0 by the piall lift	ic deductible
Additional Notes.		.cc visit specific co	se sharing is applyi		ce settings.					
Calculation Time:	0.0391 seconds									
Calculation rine.	O.OJJI SECUITOS									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	ition			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		15	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletii	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$750.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$7,5	00.00								
MOOP if Separate (\$)										
							-			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	All
Emergency Room Services	>	✓	72%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Filliary Care visit to Treat arrinjury or filliess (exc. Freventive, and A-rays)		Ш		\$20.00	Ц	Ц				
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$40.00		-				
Services				\$40.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$20.00						
				¢20.00						
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	✓	✓								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	✓	✓								
	✓				_	_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:	•		Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-A6						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001003	2-01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	cent de minimis v	ariation.						
Actuarial Value:	82.37%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ng is applying to x	rays in office setti	ngs.					
Additional Notes:										
Calculation Time:	0.0352 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 umaar corner	Dation 7 and dist.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		er 1 Plan Benefit De	1			2 Plan Benefit I				
Deductible (\$)	\$750.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)		500.00		-		1				
MOOP if Separate (\$)		100.00		-						
moor ii separate (y)							1			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Town of Donnells	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	after dadtible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible:
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V	✓	72%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$40.00						
Services	L									
Imaging (CT/PET Scans, MRIs)	V	v		¢20.00						
Speech Therapy				\$20.00						
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		_ _	100%	70.00						
X-rays and Diagnostic Imaging	V	☑	10070							
Skilled Nursing Facility	✓	✓								
	V	✓								_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<u> </u>	⊻								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00		Ш				
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		٦	Plan Description							
Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-A6 41842DC001003	2.01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	2-01					
# Days (1-10):			issuci filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		itside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	83.28%									
Metal Tier:	NOTE: One or	ro consider are act	cubiact to the ded	uctible and have a	a consu. Ani: co	avica with this so	et charing etroet	ic covered at	100% by the plan in t	ho doductible
Additional Nation		ire services are not ice-visit-specific co				vice With this CO	st-snaring structure	: is covered at	100% by the plan in t	ie deductible
Additional Notes:	range. NOTE. UII	icc-visit-specific CO	or anathig is applyi	IIIB to A-Idys III OIII	ce settings.					
Calculation Times	0.0353 '									
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Collett	bation Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
		1 Plan Benefit De	esign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$750.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$7,50	0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	v after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	✓	72%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	>	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
rilliary Care visit to freat arrinjury or filless (exc. Freventive, and X-rays)				\$20.00	_					
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$40.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	v	50%	\$250.00						
Speech Therapy				\$20.00						
				\$20.00						
Occupational and Physical Therapy		1								
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	•	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	34%	\$250.00						
			31,0	Q230.00						
Outpatient Surgery Physician/Surgical Services	>	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A6_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001003	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Cons.	f1								
	Calculation Success	rui.								
	79.65%									
	Gold		ta a ta a a a b da a t		NOTE: S		abanton ta anat 1	6	with for Joseph .	
		-		rays in office settir	igs. NOTE: Servi	ice-specific cost-	snaring is applying	tor service(s)	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	i inose service(s)	1.							
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$750.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$7,50	0.00								
MOOP if Separate (\$)										
									I	
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			☐ All	☐ All			□ All	All
Emergency Room Services	<u> </u>	<u> </u>	72%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$40.00						
Imaging (CT/PET Scans, MRIs)	✓	✓	50%	\$250.00						
Speech Therapy			3070	\$20.00						
Special Friedly										
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		☑	100%							
X-rays and Diagnostic Imaging	✓	✓	20070							
Skilled Nursing Facility	✓	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V	34%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A6_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001003	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	tul.								
Actuarial Value:	80.90%									
Metal Tier:	Gold	_								
			•						100% by the plan in t	
Additional Notes:				ing to x-rays in offic	ce settings. NOT	E: Service-speci	tic cost-sharing is a	pplying for ser	vice(s) with fac/prof	.omponents,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	· 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		A	bution Amount:		1st	: Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Ti	er 1			Ti	er 2		Tier 1	Tier 2
Click Here for important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to		Coinsurance, if	Copay, if	i i i i i i i i i i i i i i i i i i i	TIEL Z
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	□ All	□ All	unierent	separate	□ All	□ All	unierent	separate	□ All	□ All
Emergency Room Services	☑	<u> </u>	72%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	☑ ☑	✓	7270	J250.00						

Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient						-				
Services				\$40.00						
Imaging (CT/PET Scans, MRIs)	V	✓	50%	\$250.00						
Speech Therapy				\$20.00						
				400.00		П				
Occupational and Physical Therapy		Ш		\$20.00		Ш				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	V								
	✓	✓								
Outpatient Surgery Physician/Surgical Services Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00		All				
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs		ä		\$75.00						ä
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-A6_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010032	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	81.90%									
Metal Tier:	Gold									
	NOTE: Office-visit-	specific cost-shar	ing is applying to x-	rays in office settin	gs.					
Additional Notes:										
Calculation Time:	0.0352 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier	Gold ▼									
Desired Metal Her		er 1 Plan Benefit De	ncian		Tior	2 Plan Benefit [Docian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$750.00	\$0.00	Combined		medical	5.05	Compined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)		00.00				,				
MOOP if Separate (\$)				-						
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	All			All	☐ All			□ All	All
Emergency Room Services	V	<u> </u>	72%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V			Ш					
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Constitution to the second				Ć40.00		П				
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient				\$40.00						
Services				\$40.00						
Imaging (CT/PET Scans, MRIs)	V	✓	50%	\$250.00						
Speech Therapy			3070	\$20.00						
					1					
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		7	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BQ-A6_POST_						
Specialty Rx Coinsurance Maximum:		=	Plan HIOS ID: Issuer HIOS ID:	41842DC001003	2-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	Ш		issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	-								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		=								
Calculate										
Status/Error Messages:		itside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	82.80%									
Metal Tier:		_			_				1000/1 11	
						vice with this co	st-sharing structure	s is covered at	100% by the plan in t	ne deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	st-snaring is applyi	ing to x-rays in offi	ce settings.					
Calculation Time:	0.0312 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	-		HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	-				2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D f'h D-	-1		T	. 2 Dl D 6'4 D	No. of mar.			
	Medical	1 Plan Benefit De	1	-	Medical	2 Plan Benefit D	Combined			
Deductible (\$)	\$2,000.00	Drug \$250.00	Combined		iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00									
MOOP if Separate (\$)		0.00		-						
(1)	·		•			•				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	, after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies offi	
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V			\$500.00					v	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services Imaging (CT/PET Scans, MRIs)	· ·	✓	78%	\$150.00						
Speech Therapy			78%	\$30.00						
эреест тегару										
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	<u> </u>								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	65%	\$150.00						
Outpatient racinty ree (e.g., Ambulatory Surgery Center)			0370	\$150.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	N [\$40.00					V	
Non-Preferred Brand Drugs	>			\$75.00					>	
Specialty Drugs (i.e. high-cost) Options for Additional Benefit Design Limits:			Plan Description	\$120.00		Ш				Ш
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	. 01					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Calculation Com	.c								
	Calculation Success	itui.								
	77.17% Gold									
		snecific cost-shari	ng is anniving to v	rays in office settir	ngs NOTF Sen	ice-specific cost-	sharing is anniving	for service(s) :	with fac/prof compo	nents overriding
	outpatient inputs fo			.a,s in office settii	.po. 1401L. JelV	.cc specific cost-	S. Gring is applying		rac, pror compo	overriumg
Additional Notes.	2 2. potierie inputo it									
Calculation Time:	0.0469 seconds									
Carcaration fillier	J.J. JCCUIIUS									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s		ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Collett	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)				-						
,			_			•	•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	□ All	☐ All			□All	☐ All			□ All	☐ All
Emergency Room Services	✓			\$500.00	-				✓	
All Inpatient Hospital Services (inc. MH/SUD)	✓			\$500.00	_				✓	
All imputerit riospitar services (inc. willy 500)				7500.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Considiat Visit	V			\$60.00					V	
Specialist Visit				300.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services			700/	4450.00						
Imaging (CT/PET Scans, MRIs)	V	v	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					✓	
	v	V	550/	4450.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<u> </u>	⊻	65%	\$150.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	. 01					
# Days (1-10):			issuci filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Cons	f1								
Status/Error Messages:	Calculation Success	iui.								
Actuarial Value:	78.39%									
Metal Tier:	Gold								4000/1 11 1 1	
							-		100% by the plan in	
Additional Notes:				ing to x-rays in offic	ce settings. NOT	E: Service-specif	ric cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpatier	nt inputs for thos	e service(s).							
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	ition			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Collett	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)				-						
			_			•				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	☐ All	☐ All		·	☐ All	☐ All			□ All	☐ All
Emergency Room Services	✓			\$500.00					✓	
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>			\$500.00					✓	
All imputerit riospitar services (inc. wiriy 500)				7500.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Considiat Visit	V			\$60.00					V	
Specialist Visit	•			\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services				4	_					
Imaging (CT/PET Scans, MRIs)	<u> </u>	<u> </u>	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				·						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	✓			\$500.00					V	
	✓	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	▼	•				ш				
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			□ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00					✓	
Non-Preferred Brand Drugs				\$75.00					✓	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00					✓	
Options for Additional Benefit Design Limits:	_		Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-A7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	401					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	79.07%									
Metal Tier:	Gold									
	NOTE: Office-visit-	specific cost-shari	ing is applying to x-	rays in office setti	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?							<u>.</u>			
Desired Metal Tier	Gold ▼									
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000	0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Type of Belletic	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copu, applies oill,	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	All
Emergency Room Services	✓			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Drimony Core Visit to Treet on Injury or Illness (over Dreventing and Visual)				¢20.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00	_	_				_
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00		_			-	
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
						_				
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Success	f1								
	79.92%	iui.								
	79.92% Gold									
		consisos aro ant	cubiost to the ded	uctible and have se	consu Anices	wico with this so	ct charing structure	is covered at	100% by the plan in t	ho doductible
						vice with this CO	ac-andring Structure	is covered at	100% by the plan in t	ne deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	ist-snaring is applyi	IIB IO X-IAYS IN OFFIC	e settings.					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii idar Correri	bactorry unloane.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De	1			2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00	0.00								
MOOP if Separate (\$)							l			
Click Hore for Improvement Instructions		Tie	1			т:	er 2		Tiau 1	Tier 2
Click Here for Important Instructions	Cublinate	Tie		C 16	Cubicata			C 'f	Tier 1	Her Z
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if different	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	airrerent	separate	□ All	☐ All
				Ć500.00						
Emergency Room Services	V	✓		\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
	V			450.00					V	
Specialist Visit	v			\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services	V	V	78%	\$150.00						
Imaging (CT/PET Scans, MRIs) Speech Therapy			78%	\$30.00					·	
Speech Therapy		·····		\$30.00						
Ossumational and Physical There are				\$30.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		<u> </u>		\$0.00						
X-rays and Diagnostic Imaging	V	<u>v</u>								
Skilled Nursing Facility	V			\$500.00					✓	
Skilled Norsing Facility		·····		\$500.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	✓	65%	\$150.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00					✓	
Non-Preferred Brand Drugs				\$75.00					✓	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Success	ful.								
	77.31%									
Metal Tier:	Gold									
	NOTE: Office-visit-s	pecific cost-shari	ing is applying to x-	rays in office settir	ngs. NOTE: Servi	ce-specific cost-	sharing is applying	for service(s)	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	r those service(s)).							
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	ibution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		74111001 001101	ibacioni / unio anc.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De	1	-		2 Plan Benefit				
Destructible (A)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)	\$2,000.00 100.00%	\$250.00 100.00%								
MOOP (\$)	\$6,00			-						
MOOP (\$)	\$0,00	0.00		-						
WOOF II Separate (3)			•				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1.49.1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	y after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Drimon, Coro Visit to Treat on Injury or Illness (over Brownting and Visus)				¢20.00	_	_				_
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00		П				
Services					_					
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy	П			<u> </u>	_					
Preventive Care/Screening/Immunization			1000/	\$0.00						
Laboratory Outpatient and Professional Services X-rays and Diagnostic Imaging		▽	100%							
Skilled Nursing Facility	<u> </u>			\$500.00						
Skilled Nulshig Facility				\$300.00	_					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	65%	\$150.00						
Outpatient Surgery Physician/Surgical Services	✓	V								
Drugs	□ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					•	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	>			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
	78.53%									
Metal Tier:	Gold									
							-		100% by the plan in	
Additional Notes:				ng to x-rays in offic	ce settings. NOT	E: Service-speci	fic cost-sharing is a	pplying for se	rvice(s) with fac/prof	components,
	overriding outpatie	nt inputs for thos	e service(s).							
Calculation Time:	0.0508 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	ition			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1s	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,0	00.00								
MOOP if Separate (\$)							·			
			- '				-			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	All
Emergency Room Services	✓✓			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
rilliary care visit to freat arrinjury or filless (exc. Freventive, and A-rays)	_			\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00	_	_				_
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy		Ш		\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	✓			\$500.00					✓	
						_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	✓								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-A7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		ı								
Calculate										
Status/Error Messages:	Calculation Succe	ssful.								
Actuarial Value:	79.28%									
Metal Tier:	Gold									
		-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:			, 0	,	-					
Calculation Time:	0.0508 seconds									
Final 2020 AV Calculator	o.oooo seconus									
riiiai 2020 AV Caltuiditii										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bution Amount.		2nd	Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit [Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000	0.00								
MOOP if Separate (\$)										
			_			_				
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
20.11.1	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	All		4	□ All	☐ All			All	All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	₹.	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00		Ä			V	
Specialty Drugs (i.e. high-cost)	V			\$120.00		H			V	
Options for Additional Benefit Design Limits:	· ·		Plan Description:						·	
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7						
Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040064	. 01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842000040062	-01					
# Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Success	ful.								
	80.15%	- '								
Metal Tier:	Gold									
		services are not	subject to the dod	ictible and have so	conav Anycor	vice with this co	st-sharing structure	is covered at	100% by the plan in t	he deductible
	range. NOTE: Office					c with this CO	or anaring attracture	covereu di	20070 by the plantill i	acaactible
Additional Notes:	gc. NOTE. OTTO	a visit specific CO	or onaring to apply!	co x ruys iii oi iic	e securigs.					
- L L :: -	0.0500									
Calculation Time:	0.0508 seconds									

Marie Mari	User Inputs for Plan Parameters										
Apply aller framework place (prograph of the program of the progra	Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	otion			
Western development Motion for Motifical and Tong Sprortings Continued Motion 19 The State Received Colors T	Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	n? 🗆						
Use Separate Model and to Equate Management of Linear Plan Neets CR or Departed Hard Top Departed Hard	****		Annual Contri	hution Amount:							
Desired Metal Type Tier 2 Plan Benefit besign Moders (Note Springer Springer) Moders (Note Springer Springer) Moders (Note			7 iiii dai contii	Dation 7 and dist.		2nd	l Tier Utilization:				
Type of Benefits Debug Special Consumers (p. Incomer's cost Share) Special	•										
Colonsurance Description Section Description Section Description Section Description	Desired Metal Tier					_					
Consurance (H. Inserer's Case) MOOP # Separate (P) Sobject to So				1							
Colourance (K, Insurance) Costs barried (B) MODP I Separate (B) Type of Benefit	Doductible (¢)			Combined		iviedicai	Drug	Combined			
MODP #5 Sparate to 1 Type of Benefits Type of Benefits Subject to Subject to Colourance, if Subject to Subject to Colourance, if Subject to Colourance, if Subject to Subject to Colourance, if Subje											
Click harse for important industrations					•		L				
Title 1 Title 2 Type of facefit			100.00		-						
Type of Benefit Medical Additional Models	moor in separate (\$)							1			
Medical	Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Medical	- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	after deducable lat
Emergency floom Services S S S500.00	Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different		Copay applies only	after deductible:
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	Medical	☐ All	☐ All				All			☐ All	☐ All
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	Emergency Room Services				\$500.00						
Specialist Visit	All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Specialist Visit	Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		П		\$30.00						
Services	<u></u>	V			\$60.00					V	
Services MRIs)	· ·	П	П		\$60.00						
Speech Therapy Cecupational and Physical Therapy Cecupational Physical Therapy Cecupational Physical Physical Physical Services Cecupational				F.C.0/	ć200.00						
Occupational and Physical Therapy Preventive Care/Screeining/Immunization Laboratory Outputient and Professional Services X rays and Diagnostic Imaging X r			~~~~~~~	56%	~~~~~~~	···					
Occupational and Physical Therapy Preventive Care/Screening/Immunization Laboratory Outpatient and Professional Services Silled Nursing Facility Outpatient facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Outpatient	Speech Therapy				\$30.00						
Proventive Care/Screening/Immunisation Laboratory Outpatient and Professional Services Virays and Diagnostic Imaging Visited Nursing Pacility Violutation Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Outpatient Surgery	Occupational and Physical Therapy				\$30.00						
Laboratory Outpatient and Professional Services			П		\$0.00						
X-ray and Diagnostic Imaging Sollied Nursing Facility Outpatient Surgery Physician/Surgical Services Outpatient Surgery Physician Surgical Services Outpatient Surgery Phy					70.00						
Skilled Nursing Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Outpatient Surgery Physician Physician Surgery Physician											
Outpatient Surgery Physician/Surgical Services Drugs		✓			\$500.00						
Outpatient Surgery Physician/Surgical Services Drugs	Outrotiont Facility Fac (a.g. Ambulaton Surgery Contar)			310/	¢200.00					П	
Generics All All Status All All	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			31%	\$300.00						
Generics						_					
Preferred Brand Drugs S40.00 S75.00 S75.00 Specialty Prus (s. high-cost) S75.00 S97.00 S											
Specialty Drugs (i.e. high-cost)			~~~~~~~								
Specialty Drugs (i.e. high-cost) Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments? Set a Maximum Number of Days for Charging an IP Copay? Begin Primary Care Cost-Sharing After a Set Number of Usits? Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10): Copays: # Copays (1-10): Copays: # Colculate Status/Error Messages: Actuarial Value: Actuarial Value: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).			~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~								
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Ucopays? # Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10): Output Calculate Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation. Actuarial Value: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).											
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum: Specialty Rx Coinsurance Maximum: Begin Primary Care Cost-Sharing After a Set Number of Visits? Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10): Calculate Status/Error Messages: Actuarial Value: To Actuarial Value: MOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding applying for service(s) with fac/prof components, overriding applying for service(s).		V		Plan Description	-	Ш	Ш				ш
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Wisits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays? # Copays (1-10): **Output** **Calculate** Status/Error Messages: Actuarial Value: **Mote: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).		П	7	•							
Set a Maximum Number of Days for Charging an IP Copay?						64-01					
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays? # Copays (1-10): Output Calculate Status/Error Messages: Actuarial Value: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).											
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10): Coltput											
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10): Output Calculate Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation. Actuarial Value: 75.88% Metal Tier: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).	Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
Copays? # Copays (1-10): Output Calculate Status/Error Messages: Actuarial Value: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).	# Visits (1-10):										
Calculate Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation. Actuarial Value: 75.88% Metal Tier: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).											
Output Calculate Status/Error Messages: Sta											
Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation. Actuarial Value: 75.88% Metal Tier: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).											
Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation. Actuarial Value: 75.88% Metal Tier: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).											
Actuarial Value: 75.88% Metal Tier: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).		Error: Bosult is a	tsido of [4 12] ===	reant de minimis :	ariation						
Metal Tier: NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).			itside oi [-4, +2] pei	icerit de minimis va	andtion.						
NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).		73.00/0									
Additional Notes: outpatient inputs for those service(s).	The control of the co	NOTE: Office-visit	t-specific cost-shar	ing is applying to x-	-rays in office setti	ngs, NOTE: Serv	ice-specific cost	-sharing is applying	for service(s)	vith fac/prof compor	ents, overriding
	Additional Notes:				. ,	J					,
Calculation Time: 0.0391 seconds	, additional Hotes.			•							
	Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	· 🗆		HSA/HRA Options		Tie	ered Network Op	ition			
Apply Inpatient Copay per Day?	· 🗆	HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	ibution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	ncian	П	Tion	2 Dlan Panofit F	Nosian			
	Medical	Drug	Combined	+	Medical	2 Plan Benefit D	Combined			
Deductible (\$'		\$250.00	Combined		Wiedical	Diug	Combined			
Coinsurance (%, Insurer's Cost Share		100.00%								
MOOP (\$)				1						
MOOP if Separate (\$				-						
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	y after deductible?
· ·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□All	□ All		4	☐ All	☐ All			□ All	☐ All
Emergency Room Services	V			\$500.00					✓✓	
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>	Ц		\$500.00	Ш	Ц				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				······································					***************************************	
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓	56%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00	П	П				П
Occupational and Physical Therapy					_	_				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	V			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	31%	\$300.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00					0	
Preferred Brand Drugs	✓			\$40.00					✓	
Non-Preferred Brand Drugs				\$75.00					✓	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	· 🗆		Name:	BQ-A7_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	77.20%									
Metal Tier:	Gold									
	NOTE: One or more						-			
Additional Notes:	range. NOTE: Office			ng to x-rays in offic	ce settings. NO	E: Service-specif	ic cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpatier	nt inputs for thos	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	-		HSA/HRA Options		1	ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	ibution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		/ unidai contri	iodelott / titlodite.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De				2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			т	ier 2		Tier 1	Tier 2
Click Here for important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	□ All	□ All	uniterent	зерагате	□ All	All	unierent	separate	□All	☐ All
Emergency Room Services	▽			\$500.00					☑ ∧□	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00	Ī				V	
All impatient nospital services (inc. Min/300)				\$300.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		450.00	_	_			_	_
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00		_				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	∨	V								
Skilled Nursing Facility	✓			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpotient Current Physician (Curried Consider	V	V								
Outpatient Surgery Physician/Surgical Services Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V	Ö		\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					₹	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-A7_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	78.70%									
Metal Tier:	Gold	_								
	NOTE: Office-visit-s	specific cost-shar	ing is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	ition			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1s	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier 1	Plan Benefit De	esign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000	.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductibl
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Filliary Care visit to freat arrinjury or filliess (exc. Freventive, and x-rays)				\$50.00	Ц	Ц				Ц
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00	_	-				_
Services										
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy	1			\$30.00	_	_			<u> </u>	_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	~								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient racinty ree (e.g., Ambulatory Surgery Center)						_				
Outpatient Surgery Physician/Surgical Services	>	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040064	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successf	ul.								
Actuarial Value:	79.56%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the dedu	uctible and have no	copay. Any sei	vice with this co	st-sharing structure	is covered at	100% by the plan in t	he deductible
Additional Notes:	range. NOTE: Office								•	
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar Cornerii			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De	1			2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		-		<u> </u>				
MOOP (\$)		00.00								
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	ur 1			т:	er 2		Tier 1	Tier 2
CHECK TETE TOT IMPORTANCE MISTERCHOTS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	TICI I	TICL 2
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	, after deductible
Medical	All	□ All	unicidate	Separate	All	All	umeren	зерание	□ All	☐ All
Emergency Room Services	✓			\$500.00					v	
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						_
Occupational and Physical Therapy				\$30.00						<u> </u>
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V	31%	\$300.00						
			3170	7500.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	<u> </u>			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-A7_POST_ 41842DC004006	4.01					
Set a Maximum Number of Days for Charging an IP Copay?		-	Issuer HIOS ID:	41842DC004006 41842	4-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	-								
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	75.99%									
Metal Tier:										
				rays in office settir	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s) v	vith fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs	for those service(s)								
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?	_				2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		Dian Danafit Da	-1		T'	2 Dl D	D1			
	Medical	1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit Drug	Combined			
Deductible (\$)		Drug \$250.00	Combined		Wedical	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)				-		1				
MOOP if Separate (\$)				-						
			•		ı	•	•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Consy applies only	after deductible?
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies offi	arter deductible:
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services			5.50/							
Imaging (CT/PET Scans, MRIs)	V	<u> </u>	56%	\$300.00 \$30.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services			100%	30.00						
X-rays and Diagnostic Imaging	V	V	10070			_				Ī
Skilled Nursing Facility	✓			\$500.00	Ö				✓	
					_					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	31%	\$300.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	~			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID: Issuer HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			issuer HIOS ID:	41642						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	77.30%									
Metal Tier:	Gold	_								
			-				_		100% by the plan in	
Additional Notes:				ing to x-rays in offic	ce settings. NOT	E: Service-speci	tic cost-sharing is a	ppiying for ser	vice(s) with fac/prof	components,
	overriding outpatier	it iriputs for those	e sei vice(s).							
Calculation Time:	0.0352 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		A C	ibution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	ibution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Ti	er 1			Ti	er 2		Tier 1	Tier 2
Click Here for important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	i i i i i i i i i i i i i i i i i i i	Hei Z
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	□ All	□ All	uniterent	зерагате	All	□ All	unierent	separate	□ All	□ All
Emergency Room Services	☑			\$500.00					Z	
All Inpatient Hospital Services (inc. MH/SUD)	v	V		,300.00						
All important riospital services (inc. 1411/3500)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient						_				
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	✓	✓	56%	\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	<u> </u>								
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	~			\$500.00					✓	
	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										Ш
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	✓			\$40.00					V	
Non-Preferred Brand Drugs	✓			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040064	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	-ful								
Actuarial Value:	78.90%	orui.								
	78.90% Gold									
Metal Tier:	NOTE: Office-visit-	enecific cost short	ing is applying to	rave in office setting	uae					
Additional Notace	NOTE. Office-VISIT-	specific cost-snar	ing is applying to X-	rays in ornice settin	gs.					
Additional Notes:										
0.1.1.1										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dan Coman	Dation 7 unio ant.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
		1 Plan Benefit De	1	+		2 Plan Benefit D				
Deductible (\$)	\$2,000.00	Drug \$250.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000			•						
MOOP if Separate (\$)	\$0,000	3.00		-						
			_				1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Towns of Description	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services			550/		_					
Imaging (CT/PET Scans, MRIs)) [V	56%	\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		<u> </u>	100%	30.00						
X-rays and Diagnostic Imaging	<u> </u>	<u> </u>								
Skilled Nursing Facility	✓			\$500.00					✓	
	V	✓				-				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		⊻								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A7_POST_	4.04					
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay?			Plan HIOS ID: Issuer HIOS ID:	41842DC004006	4-01					
# Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
. 9	Calculation Success	ful.								
	79.76%									
	Gold									
						rvice with this co	st-sharing structure	s is covered at	100% by the plan in t	ne deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-snaring is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:		1s	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	Julion Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,2	50.00								
MOOP if Separate (\$)										
			_							
Click Here for Important Instructions		Tie	r 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
•	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	_ All
Emergency Room Services	N N	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
rilliary care visit to freat arrinjury or filliess (exc. Freventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00	_	-				
Services				300.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy		ш		\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	•	✓								
	V	✓				_				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		⊻								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A8						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001005	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	82.37%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$4,2	50.00				•				
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	1			т:	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Canau if	Subject to	Subject to	Coinsurance, if	Canan if	Heri	Her Z
Type of Benefit	Deductible?	Coinsurance?	different	Copay, if separate	Deductible?	Coinsurance?	different	Copay, if separate	Copay applies only	after deductible
Medical	□ All	□ All	uniterent	separate	□ All	□ All	uniterent	зерагате	☐ All	☐ All
Emergency Room Services	✓	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓								
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization		П		\$0.00						
Laboratory Outpatient and Professional Services			100%	40.00	_					
X-rays and Diagnostic Imaging	✓	✓	20070							
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics	0			\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		_	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A8						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001005	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	Ш									
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	83.31%									
Metal Tier:	NOTE: O		and the second second	continue of the		and an analysis of the	an abandan i i i		4.0007	Alexandra de 1900
			-			vice with this co	st-snaring structure	e is covered at	100% by the plan in	ine deductible
Additional Notes:	range. NOTE: Offi	ice-visit-specific co	sc-snaring is applyi	ing to x-rays in offic	Le settings.					
Calculation Times	0.0301 6									
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	-		HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	-				2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier						221 2 6:5				
		1 Plan Benefit De	1	+		2 Plan Benefit D				
Deductible (\$)	Medical \$1,250.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,25			•						
MOOP if Separate (\$)	54,23	0.00		-						
moor in separate (y)			_				ı			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	6	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
rimary care visit to freat armijury or limess (exc. Freventive, and x-rays)				\$30.00	_					
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	50%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				¢0.00		_				
Preventive Care/Screening/Immunization Laboratory Outpatient and Professional Services		□		\$0.00						
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	<u> </u>								
Skilled Nulsing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	34%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A8_POST_						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001005	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	80.99%									
Metal Tier:	Gold									
				rays in office settir	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s) v	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs for	or those service(s)	i.							
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	S		ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,2	50.00				•				
MOOP if Separate (\$)				-						
		•	-			•	-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
- 4- 4:	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	y after deductible?
Medical	☐ All	☐ All			□ All	☐ All			☐ All	☐ All
Emergency Room Services	V	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	v	☑								
All impatient mospital services (inc. Willy 300)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Constalled Visit				¢co.00						
Specialist Visit	Ш			\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										_
Imaging (CT/PET Scans, MRIs)	V	V	50%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy	_	_		450.00	_	_			_	_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	✓								
				4	_	_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	34%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			□ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description	•						
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BQ-A8 POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001005	<i>1</i> -01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	4-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	82.13%									
Metal Tier:										
			-				-		100% by the plan in	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-speci	fic cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpation	ent inputs for those	e service(s).							
Calculation Time:	0.0352 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	ition			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:		15	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,2	50.00								
MOOP if Separate (\$)										
							-			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			☐ All	☐ All			□ All	All
Emergency Room Services	>	_								
All Inpatient Hospital Services (inc. MH/SUD)	V	V			Ш	Ц				Ц
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
				450.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services	L			4	_					
Imaging (CT/PET Scans, MRIs)	V	<u> </u>	50%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				40.00	_	_				
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services	V	<u> </u>								
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	✓	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BQ-A8 POST						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001005	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	cent de minimis v	ariation.						
Actuarial Value:	82.02%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ng is applying to x	rays in office setti	ngs.					
Additional Notes:										
Calculation Time:	0.043 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	i? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Fiel		r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$4,2	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	vr 1			Ti	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	□ All	□ All	uniciciii	Separate	All	All	uniciciii	ocpulate.	☐ All	☐ All
Emergency Room Services	✓	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								_
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient						_				
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	☑	✓	50%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy									J.	_
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	V V								
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00		_				_
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)			Dian Danielation	\$120.00						
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		1	Plan Description Name:	BQ-A8 POST						
Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001005	<i>4</i> -01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	4-01					
# Days (1-10):			133461 11103 15.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status / France Massacces	Frank Decult /	noide of [4 12]	name da minimi-1- · · ·							
Status/Error Messages: Actuarial Value:	82.96%	tside of [-4, +2] per	cent de minimis va	driduON.						
Metal Tier:	02.30%									
meta nen	NOTE: One or mor	re services are not	subject to the ded	uctible and have no	copav. Anv sei	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:			-	ing to x-rays in office		**********************************	or or arming our actum	covered at	20070 by the plantin	c acadensie
Additional Notes.	. 32			J						
Calculation Time:	0.0547 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:		15	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De				2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%		-						
MOOP (\$)		50.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tie	. 1			т:	ier 2		Tier 1	Tier 2
Circk Here for important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	TIEL I	1161 2
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	, after deductible
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V	•								
All Inpatient Hospital Services (inc. MH/SUD)	☑	✓								
	_			400.00					_	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	_			\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services				Ţ00.00		_				
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy	_				_					
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services	V									
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	□ All			☐ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:	,		Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A9						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004009	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output # Copays (1-10).										
Calculate										
Status/Error Messages:	Error: Result is our	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	82.37%	o. [., .z] pci	ac							
Metal Tier:	,,,									
	NOTE: Office-visit	-specific cost-shari	ng is applying to x-	ravs in office setti	ngs.					
Additional Notes:	2.2.2	., 3030 3.1011	0 .5 -FF.1.1.16 to x	. ,	J					
Additional Motes.										
Calculation Time:	0.0625 seconds									
Final 2020 AV Calculator	5.555 5000.NG5									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?		-	HSA/HRA Option:			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$4,2	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	1			т:	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Canau if	Subject to	Subject to	Coinsurance, if	Canan if	Heri	Her Z
Type of Benefit	Deductible?	Coinsurance?	different	Copay, if separate	Deductible?	Coinsurance?	different	Copay, if separate	Copay applies only	after deductible
Medical	□ All	□ All	uniterent	separate	□ All	□ All	uniterent	зерагате	☐ All	☐ All
Emergency Room Services	▽	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		☑	100%	40.00	_					
X-rays and Diagnostic Imaging	✓	✓	20070							
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		-	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A9						
Specialty Rx Coinsurance Maximum:		4	Plan HIOS ID:	41842DC004009	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?		4								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П	1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	83.31%									
Metal Tier:	NOTE: O		and the same of the same	continue of the		and an analysis of the	an abandan i i i		4.0007	Alexandra de 1900
			-			vice with this co	st-snaring structure	e is covered at	100% by the plan in	ine deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	sc-snaring is applyi	ing to x-rays in offic	Le settings.					
Calculation Times	0.0301 6									
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau.	_	Tion	2 Plan Benefit D	a sign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,25									
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie	r 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to		Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V				Ш				Ц	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				······					*	
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓	50%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy									_	
Preventive Care/Screening/Immunization	<u> </u>			\$0.00	_					_
Laboratory Outpatient and Professional Services	V	<u> </u>								
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V	34%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description Name:							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	BQ-A9_POST_ 41842DC004009:	1_01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	1-01					
# Days (1-10):				12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	eful								
Actuarial Value:	80.99%	nui.								
Metal Tier:	Gold									
		specific cost-shari	ng is applying to x-	rays in office settir	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s)	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	•			5 - 75	p	0 7 - 0		, ,	-,
	•									
Calculation Time:	0.0312 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,2	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	y after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	✓	V	50%	\$250.00						
Speech Therapy				\$30.00						
SPECETI THE OFF										
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization	П			\$0.00						
Laboratory Outpatient and Professional Services			100%	J 0.00		_				
X-rays and Diagnostic Imaging	<u> </u>	V	100/6							
Skilled Nursing Facility	V	✓								
Skilled (Vd) Sing 1 activity										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	₹	34%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		-	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A9_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004009	91-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Error: Result is out	tside of [-4, +2] per	rcent de minimis va	ariation.						
	82.13%									
Metal Tier:										
			•						100% by the plan in	
	-			ng to x-rays in offi	ice settings. NOT	E: Service-spec	ific cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:		15	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	dition Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De				2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)		50.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tie	r 1			Ti	ier 2		Tier 1	Tier 2
Click Here for Important Histractions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	, after deductible
Medical	☐ All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services	V	•								
All Inpatient Hospital Services (inc. MH/SUD)	☑	✓								
	_			400.00					_	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00		П				
Services	L					_				
Imaging (CT/PET Scans, MRIs)	V	V	50%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services	_	<u> </u>				_				
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						_
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-A9_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004009	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Error: Result is our	tside of [-4, +2] per	cent de minimis va	ariation						
Actuarial Value:	82.02%	c or [4, +2] per	cent de minimi V							
Metal Tier:	02.02/0									
The same of the sa	NOTE: Office-visit	-specific cost-shari	ng is applying to v-	rays in office setting	ngs.					
Additional Notes:	2	., 3030 3.1011	2 J 6 t. 2 x	,	J					
Additional Notes.										
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator	0.0331 SECURUS									
· · · · · · · · · · · · · · · · · · ·										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?		-	HSA/HRA Option:			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$4,2	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	-1			т:	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Conou if	Subject to	Subject to	Coinsurance, if	Conov if	rier 1	Hei Z
Type of Benefit	Deductible?	Coinsurance?	different	Copay, if separate	Deductible?	Coinsurance?	different	Copay, if separate	Copay applies only	after deductible
Medical	□ All	□ All	uniterent	зерагате	□ All	□ All	uniterent	зерагате	☐ All	□ All
Emergency Room Services	▽	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	V	∠								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		450.00	_	_			_	_
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	50%	\$250.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		✓	100%							
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						_
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		7	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-A9_POST_						
Specialty Rx Coinsurance Maximum:		4	Plan HIOS ID:	41842DC004009	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):		4								
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	Ш									
Begin Primary Care Deductible/Coinsurance After a Set Number of	П	1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	82.96%									
Metal Tier:		_								
						vice with this co	st-sharing structure	is covered at	100% by the plan in	he deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	st-snaring is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Fler		r 1 Plan Benefit De	neian		Tio	2 Plan Benefit D	Dosign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$		\$0.00	Combined		carear	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$6,5	00.00				•				
MOOP if Separate (\$)										
Cital: Harri for large sets of		T1.	er 1			-	er 2		714	Tier 2
Click Here for Important Instructions	Cubicatta			Comer: if	Cubinetta			Caman if	Tier 1	Her 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only	after deductible?
Medical	□ All	□ All	unterent	зериние	□ All	□ All	unterent	Separate	□ All	☐ All
Emergency Room Services	<u> </u>	<u> </u>	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓				_				
Discontinuo de la contraction				ć2F.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00		П				
Services	L	_		ψ50.00	_	_			_	
Imaging (CT/PET Scans, MRIs)	V	V		40= 00						
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	v			Ţ0.00						
X-rays and Diagnostic Imaging	v	✓								
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient racinty ree (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All		<u> </u>	☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs Non-Preferred Brand Drugs				\$40.00 \$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	. 🗆	1	Name:	BQ-BA						
Specialty Rx Coinsurance Maximum:	:		Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):		_								
Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of		-								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	83.47%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ing is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time: Final 2020 AV Calculator	0.0469 seconds									
rınaı 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	red Network Op	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar Cornerii			2nd	Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		er 1 Plan Benefit De	1			2 Plan Benefit I	1 -			
Deductible (\$)	Medical \$1,750.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-		l				
MOOP if Separate (\$)		100.00		-						
			•				•			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Town of Donnells	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	after dedtible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
					_					
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services		<u> </u>								
Imaging (CT/PET Scans, MRIs)				\$25.00						
Speech Therapy				\$25.00	1					
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		☑	100%	70.00						
X-rays and Diagnostic Imaging										
Skilled Nursing Facility	✓	~								
Octobring the first for the first form of the fi	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)			Dian Description	\$120.00		Ш				Ш
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		٦	Plan Description Name:	BQ-BA						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	2 01					
# Days (1-10):				12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	5 5 h:									
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value: Metal Tier:	84.32%									
ivictal fici.	NOTE: One or mo	re services are not	subject to the ded	uctible and have no	CODAY Anyser	vice with this co	set-charing etructur	is covered at	100% by the plan in t	he deductible
Additional Notes:		ice-visit-specific co				VICE WITH THIS CO	or anaring structure	. 13 covereu di	10070 by tile plair III t	ne deductible
Additional Notes.		.cc visit specific co	se sharing is applyi	x 10 y 3 11 0 111	ce settings.					
Calculation Time:	0.0508 seconds									
Calculation rine.	0.0300 SECUITOS									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau	1	Ties	2 Plan Benefit D	a sign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,750.00	\$0.00	Combined		ivicuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,50									
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie	er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to		Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All		<u> </u>	All	All			☐ All	☐ All
Emergency Room Services	v	V	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient									*	
Services				\$50.00						
Imaging (CT/PET Scans, MRIs)	V	✓	63%	\$250.00						
Speech Therapy				\$25.00						
				\$25.00						
Occupational and Physical Therapy									_	
Preventive Care/Screening/Immunization	<u> </u>			\$0.00						_
Laboratory Outpatient and Professional Services	V	<u> </u>								
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V	42%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description Name:							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	BQ-BA_POST_ 41842DC0010042	2_01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	2-01					
# Days (1-10):				12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	eful								
Actuarial Value:	79.13%	nui.								
Metal Tier:	Gold									
		specific cost-shari	ng is applying to x-	rays in office settir	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s)	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	•						,		
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,750.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,50	0.00								
MOOP if Separate (\$)										
Í									1	
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			All	_ All			□ All	All
Emergency Room Services	<u> </u>	<u> </u>	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				, , , , , , , , , , , , , , , , , , ,						
Services				\$50.00						
Imaging (CT/PET Scans, MRIs)	V	V	63%	\$250.00						
Speech Therapy			0370	\$25.00						
Specifically										
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services			100%	30.00						
X-rays and Diagnostic Imaging		V	10070							
Skilled Nursing Facility	V	<u>v</u>								
Skilled IVdISing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	42%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BA_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	80.45%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in t	he deductible
Additional Notes:	range. NOTE: Offic	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings. NOT	E: Service-speci	fic cost-sharing is a	applying for ser	vice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Fler		r 1 Plan Benefit De	neian		Tio	· 2 Plan Benefit D	Dosign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$6,5	00.00				•				
MOOP if Separate (\$)										
Clinic Harry for large sets at		T1.	er 1			-	er 2		Tier 1	Tier 2
Click Here for Important Instructions	Cubicatta			Caman if	Cubinetta			Caman if	Her 1	Her 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only	after deductible?
Medical	□ All	□ All	unterent	Separate	□ All	□ All	unterent	Separate	□ All	☐ All
Emergency Room Services	<u> </u>	<u> </u>	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Discos Convictor Texts a laise and line of the December and Vision 1				¢25.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00		П				
Services	L				_	_			_	
Imaging (CT/PET Scans, MRIs)	V	V	63%	\$250.00						
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	v			Ų0.00						
X-rays and Diagnostic Imaging	_ _	-								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs Generics	□ All	□ All		\$10.00	All	☐ All			□ All	☐ AII
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						ä
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							-
Set a Maximum on Specialty Rx Coinsurance Payments?	· 🗆		Name:	BQ-BA_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?		-								
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	riation.						
Actuarial Value:	82.64%									
Metal Tier:	NOTE: Office visit	-specific cost shari	ing is anniving to ::	rays in office settir	oge					
Additional Notes:	NOTE. OTTICE-VISIT	-specific cost-snari	ing is applying to x-	rays in office settir	ıgə.					
Additional NOTES.										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator	0.0 100 Seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	sian		Tio	· 2 Plan Benefit [Docian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,750.00	\$0.00	Companied		medical	2.08	Companied			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,5	00.00				•				
MOOP if Separate (\$)										
					I					
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to	Coinsurance, if	Copay, if	Subject to Deductible?	Subject to	Coinsurance, if different	Copay, if	Copay applies only	, after deductible
Medical		Coinsurance?	different	separate	All	Coinsurance?	amerent	separate	□ All	□ All
Emergency Room Services	<u> </u>	<u> </u>	90%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	✓	Ø	30/6	3230.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	63%	\$250.00						
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		v	100%							
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00 \$120.00						
Specialty Drugs (i.e. high-cost) Options for Additional Benefit Design Limits:	Ш	Ш	Plan Description			Ш				
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BQ-BA POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):		J								
Output Calculate										
Status/Error Messages:	Frror: Result is our	tside of [-4, +2] per	rent de minimis va	ariation						
Actuarial Value:	83.49%	or [4, +2] per	Contrac minimins Ve							
Metal Tier:	13/0									
	NOTE: One or mo	re services are not s	subject to the ded	uctible and have no	copay. Any sei	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:		ice-visit-specific co					-			
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?					1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contril	oution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?					•					
Desired Metal Tier										
Desired Wetar Her		1 Plan Benefit De	cian	1	Tior	2 Plan Benefit D	ocian			
	Medical	Drug	Combined	1	Medical	Drug	Combined			
Deductible (\$)	\$250.00	\$0.00	Combined		Wieulcai	Diug	Combined			

Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$2,50	0.00								
MOOP if Separate (\$)										
						_	_			
Click Here for Important Instructions	Subject to	Tie Subject to	Coinsurance, if	Copay, if	Subject to		coinsurance, if	Copay, if	Tier 1	Tier 2
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	□ All	□ All	unierent	separate	□ All	□ All	unierent	зерагате	□ All	□All
				4250.00		AII				All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V			Ī					
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
					_					
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services				750.00						
Imaging (CT/PET Scans, MRIs)	V	v								
Speech Therapy				\$15.00						
				445.00		П				
Occupational and Physical Therapy	Ш			\$15.00	Ш	Ш				
Preventive Care/Screening/Immunization		П		\$0.00		П				
Laboratory Outpatient and Professional Services				\$30.00	_					
X-rays and Diagnostic Imaging		ä		\$30.00	Ē					
	<u> </u>	✓		\$30.00						
Skilled Nursing Facility	V	V							Ш	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
					_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description:		•					
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-BB						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004005	9_01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	5 01					
# Days (1-10):			issuci illos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
,										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	itul.								
Actuarial Value:	90.12%									
Metal Tier:	Platinum									
Additional Notes:										
Calculation Time:	0.0508 seconds									
Final 2020 AV Calculator	2.3300 30001103									
Tillal Eded Av Cultulator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar corners			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
		r 1 Plan Benefit De	1			2 Plan Benefit D				
Deductible (\$)	\$250.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		•		l				
MOOP if Separate (\$)	\$2,3	00.00		_						
			•				1			
Click Here for Important Instructions		Tie	r 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	6	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										_
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	✓	✓								
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy				\$15.00	_	_				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$30.00						_
Skilled Nursing Facility	✓	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BB						
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay?		-	Plan HIOS ID:	41842DC0040059	9-01					
# Days (1-10):			Issuer HIOS ID:	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	-								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Succes	eful								
	91.92%	osiul.								
	Platinum									
		re services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range.	2 22, 7,000 0,0 1100	, to the deal				arm g sa acture			
, additional reduction	U -									
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$2,5	00.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies only	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Driver Company to the Toronton Indiana and March 1997				ć4 F 00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		400.00	_				_	_
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	✓	✓	61%	\$250.00						
Speech Therapy				\$15.00						
				445.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	✓	✓								
				4						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•	40%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-BB POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004005	9-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output		ı								
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	88.74%									
Metal Tier:	Platinum									
		cific cost-sharing is	s applying for servi	ice(s) with fac/prof	components, ov	erriding outpati	ient inputs for those	e service(s).		
Additional Notes:			3			J		- 1-7		
Calculation Time:	0.0352 seconds									
Calculation Time.	0.0352 Seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	cian		Tion	2 Plan Benefit D	ocian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$2,50	0.00								
MOOP if Separate (\$)				-			•			
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All		Ć250.00	All	All			□ All	All
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	✓		\$250.00						
All impatient nospital services (inc. Min/30D)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient		_			_				_	
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	v	61%	\$250.00						
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy					_					
Preventive Care/Screening/Immunization			4000/	\$0.00						
Laboratory Outpatient and Professional Services			100%	\$30.00						
X-rays and Diagnostic Imaging Skilled Nursing Facility	☑	<u> </u>		\$30.00	H					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	40%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-BB_POST_ 41842DC0040059	0.01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	9-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Calandaria a Co	£1								
Status/Error Messages: Actuarial Value:	Calculation Success 89.96%	Tui.								
Metal Tier:	89.96% Platinum									
metal tier.		services are not	subject to the ded	uctible and have no	copav. Anv sei	vice with this cos	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Servi		-				_			
, adicional research	J		0 1-1 7 - 0 -			,			• •	
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?					1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
		r 1 Plan Benefit De	esign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$250.00	\$0.00				8				
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00		Ī		1				
MOOP if Separate (\$)				-						
			_			•	<u>.</u>			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible?
Medical	☐ All	□ All	uniciciit	Separate	□ All	☐ All	unicient	Separate	□ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	☑		7250.00						
All ripatient nospital services (inc. Willy 300)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
			01%	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~						
Speech Therapy				\$15.00						
0 10				\$15.00						
Occupational and Physical Therapy	_			40.00	_					
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00	_					
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		-	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BB_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004005	9-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):]								
Output										
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	89.73%									
Metal Tier:	Platinum									
Additional Notes:										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	□ Platinum ▼									
Desired Metal Tier		r 1 Plan Benefit De	cian		Tion	2 Plan Benefit D	ocian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$250.00	\$0.00	Combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$2,5	00.00								
MOOP if Separate (\$)				 -						
·					•					
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
No. disal	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical Emergency Room Services	□ All	□ All		\$250.00	All	All			□ All	All
All Inpatient Hospital Services (inc. MH/SUD)				\$250.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00	_	_				_
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy				ć0.00	_					
Preventive Care/Screening/Immunization Laboratory Outpatient and Professional Services		□	100%	\$0.00						
X-rays and Diagnostic Imaging			100%	\$30.00						
Skilled Nursing Facility	<u> </u>	<u> </u>		\$30.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					_					
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00	_					_
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost) Options for Additional Benefit Design Limits:			Plan Description:	\$100.00	Ш					Ш
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BQ-BB_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004005	9-01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):]								
Output Calculate										
Status/Error Messages:	Calculation Succes	ssful								
. 9	91.34%									
Metal Tier:	Platinum									
		re services are not	subject to the dedu	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in t	he deductible
Additional Notes:	range.						-			
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau.	_	Ties	2 Dlaw Dawafit D	a sign			
	Medical	Drug	Combined	-	Medical	2 Plan Benefit D	Combined			
Deductible (\$)		\$250.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00			T		1				
MOOP if Separate (\$)				-						
			-			•	•			
Click Here for Important Instructions		Tie	r1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
				450.00	_					
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy			7070	\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•	65%	\$150.00						
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	v –			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description Name:	: BQ-BC						
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010084	4.01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	4-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	tul.								
Actuarial Value:	77.17% Gold									
Metal Tier:		enecific cost-shari	ng is applying to v	rave in office sottin	age NOTE: Son	ice-specific cost	charing is applying	for service(s)	with fac/prof compo	nents overriding
Additional Nator:	outpatient inputs fo	•		rays in office settin	igs. NOTE. Serv	ice-specific cost-	and this is applying	ioi seivice(s)	with rat/prof compo	ients, overriding
Additional Notes:	oacpatient inputs it	1103C 3CI VICE(S)	•							
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	oution Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00	0.00				•				
MOOP if Separate (\$)				-			•			
			-			•				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			☐ All	☐ All			□ All	All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00	<u> </u>					_
Laboratory Outpatient and Professional Services		<u> </u>	100%							_
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	65%	\$150.00						
	✓	✓		-						
Outpatient Surgery Physician/Surgical Services	□ All	□ All			All	□ All				□ All
Drugs				440.00					All	
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					<u> </u>	_
Non-Preferred Brand Drugs	V			\$75.00					V	_
Specialty Drugs (i.e. high-cost)	~			\$120.00		Ш			~	
Options for Additional Benefit Design Limits:	_		Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calandatian Comme									
Status/Error Messages:	Calculation Success	iui.								
Actuarial Value:	78.39%									
Metal Tier:	Gold		and the second second			and a second all the select	and the state of t		40000	de en al en al constitut e
			-				-		100% by the plan in t	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-specif	ic cost-snaring is a	applying for ser	vice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	? 🗆		HSA/HRA Options	5	Tie	ered Network Op	ition			
Apply Inpatient Copay per Days		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	ocian	П	Tion	· 2 Plan Benefit D	Nosian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$		\$250.00	Combined		Wicaicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share		100.00%								
MOOP (\$	\$6,00	0.00				•				
MOOP if Separate (\$)									
Click Here for Important Instructions			er 1	,			er 2	- "	Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to	Coinsurance, if different	Copay, if	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if	Copay applies only	after deductible
Medical	□ All	Coinsurance?	amerent	separate	All	All	amerent	separate	☐ All	☐ All
Emergency Room Services	✓			\$500.00					▽	
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>			\$500.00					☑ ☑	

Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00		П				
Services					_	_			_	
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
Occupational and Blooming Theorem				\$30.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	<u> </u>	✓		30.00						
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	✓			\$500.00					✓	
	V									_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs Specialty Drugs (i.e. high-cost)	V			\$75.00 \$120.00					>	
Options for Additional Benefit Design Limits:	· ·		Plan Description:						Ľ	
Set a Maximum on Specialty Rx Coinsurance Payments	? 🗆		Name:	BQ-BC						
Specialty Rx Coinsurance Maximum			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	? 🗆		Issuer HIOS ID:	41842						
# Days (1-10)										
Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10)										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copaysi # Copays (1-10)										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	79.07%									
Metal Tier:	Gold									
	NOTE: Office-visit-	specific cost-shari	ing is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?	_	HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		L Plan Benefit De	sian		Tion	· 2 Plan Benefit D	ocian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00	Combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000	0.00								
MOOP if Separate (\$)				-						
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductibl
na diad	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical	□ AII	□ All		ĆE00.00	☐ All	AII			□ All	
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00 \$500.00					V	
All impatient nospital services (inc. Min/30D)				\$300.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				······						
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy									_	
Preventive Care/Screening/Immunization				\$0.00	_					_
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging Skilled Nursing Facility	V			\$500.00					□ ▼	
Skilled Nursing Facility				\$500.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-BC 41842DC0010084	4.01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	4-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status (Free Messages)	Coloulation Cus									
Status/Error Messages: Actuarial Value:	Calculation Successf 79.92%	ui.								
Metal Tier:	79.92% Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copav. Anv ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office		-						, preside	
	-		5 117	- ,	5					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	sian		Tior	· 2 Plan Benefit [Dosign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00	Communica		Wicarear	2.08	Companed			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00	0.00				•				
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if different	Copay, if	Copay applies only	after deductible
Medical		Coinsurance?	different	separate	Deductible?	Coinsurance?	amerent	separate	☐ All	□ All
Emergency Room Services	✓			\$500.00					□	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓		3300.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	~								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V	65%	\$150.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ AII	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	N .			\$40.00		_			<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V		Plan Description	\$120.00		Ш			✓	
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	- 01					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	sful								
Actuarial Value:	77.31%									
Metal Tier:	Gold									
		specific cost-shari	ng is applying to x-	rays in office settir	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s)	vith fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo					•		. ,	•	
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s		ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	ibution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Collett	ibution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)				-						
(1)			-			•	•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		4
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	□ All	☐ All			□ All	□ All			□ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V		2300.00	Ī					
All Impatient Hospital Services (inc. Min/300)	_ U	· ·								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_	_				
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	78%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00	_	_				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	V			\$500.00					V	
						_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	65%	\$150.00						
Outpatient Surgery Physician/Surgical Services	☑	☑								
Drugs	□ All	☐ All			□ All	☐ All			□ All	☐ All
Generics	0			\$10.00						
Preferred Brand Drugs	V			\$40.00					✓	
Non-Preferred Brand Drugs	V			\$75.00					✓	
Specialty Drugs (i.e. high-cost)	☑			\$120.00					·	
Options for Additional Benefit Design Limits:	· ·		Diam Description	•					Ľ	ш
			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC	4.04					
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	78.53%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ing to x-rays in offi	ce settings. NOT	E: Service-specif	fic cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpatier	nt inputs for thos	e service(s).							
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desireu Metal Hei		1 Plan Benefit De	sign	T	Tier	· 2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00	00.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	1			т:	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	ilei 1	Hei Z
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	All	□ All	unicicii	зерилисе	☐ All	☐ All	uniciciii	Separate	☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Brimany Care Vicit to Treat an Injury or Illness (eye Broyentiye and Virgus)				\$30.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services Imaging (CT/PET Scans, MRIs)			78%	\$150.00						
Speech Therapy			78%	\$30.00						
эрест тегару										·····
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	✓			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-BC 41842DC001008	4.01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	4-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status / France Massacras	Calculation Succes	af1								
Status/Error Messages: Actuarial Value:	79.28%	Siui.								
Metal Tier:	79.28% Gold									
	NOTE: Office-visit-	specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:			5 -147 5	,	•					
Calculation Time:	0.0625 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
		L Plan Benefit De		_		2 Plan Benefit D				
Deductible (\$)	\$2,000.00	Drug \$250.00	Combined	-	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000			•		L				
MOOP if Separate (\$)				-						
moor in separate (\$)							ı			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
- (5 %)	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	-6
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductibl
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	☑				Ī				Ī
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
rimary care visit to Treat arringary or filliess (exc. Freventive, and x-rays)				730.00	_	_				
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services	L		700/		_					
Imaging (CT/PET Scans, MRIs)	V	<u> </u>	78%	\$150.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	✓	~								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC0010084	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?	_									
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successi	ul.								
Actuarial Value:	80.15%									
Metal Tier:	Gold									
			-			vice with this co	st-sharing structure	is covered at	100% by the plan in t	he deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	e settings.					
Calculation Time:	0.0781 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Aimaai contii	bation Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		er 1 Plan Benefit De	1			2 Plan Benefit I				
Destructible (A)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)	\$2,000.00 100.00%	\$250.00 100.00%								
MOOP (\$)		100.00%				1				
MOOP if Separate (\$)		1		_						
Moor in Separate (2)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible:
Medical	☐ All	☐ All		· ·	☐ All	All			□All	All
Emergency Room Services	✓			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					✓	
	_			400.00		_			_	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				ćo 00						
Preventive Care/Screening/Immunization Laboratory Outpatient and Professional Services		_ _		\$0.00						
X-rays and Diagnostic Imaging	<u> </u>	<u>v</u>								
Skilled Nursing Facility	·			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V	31%	\$300.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•			\$120.00					V	
Options for Additional Benefit Design Limits:		7	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC_POST_						
Specialty Rx Coinsurance Maximum:		-	Plan HIOS ID:	41842DC001008	34-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		+								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?	_									
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:		itside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	75.88%									
Metal Tier:		_				_		_		
				rays in office setti	ngs. NOTE: Serv	ice-specific cost	-sharing is applying	tor service(s) v	vith fac/prof compor	ents, overriding
Additional Notes:	outpatient inputs	for those service(s)).							
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		, unidai contri			2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D f't D-	-1		T'	2 Dl D 6'4 I	Davier.			
	Medical	1 Plan Benefit De	Combined		Medical	2 Plan Benefit I	Combined			
Deductible (\$)		Drug \$250.00	Combined		iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00					1				
MOOP if Separate (\$)		5.00		-						
			•				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Conay applies only	y after deductible?
· ·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Constalled Mark	✓			¢50.00					✓	
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy			3070	\$30.00						_
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		v	100%							
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	V	31%	\$300.00						
			5270	\$500.00						
Outpatient Surgery Physician/Surgical Services	V	v								
Drugs	□ All	□ All		410.00	☐ All	□ All			□All	□ All
Generics Professed Prood Proof				\$10.00					□ ☑	
Preferred Brand Drugs Non-Preferred Brand Drugs	V			\$40.00 \$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	77.20%	- *								
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the dedu	uctible and have no	copay. Any ser	rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Offic	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings. NOT	ΓΕ: Service-speci	fic cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible	? 🗆		HSA/HRA Options	5	Tie	ered Network Op	ition			
Apply Inpatient Copay per Day		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard Desired Metal Tie										
Desired Metal Tie		1 Plan Benefit De	neian		Tio	· 2 Plan Benefit D) Assign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$		\$250.00				8				
Coinsurance (%, Insurer's Cost Share		100.00%								
MOOP (\$	\$6,00	0.00				•				
MOOP if Separate (\$)			-						
Cital: Harri for large extent in the extent in a		T1	er 1			-	er 2		T14	Tier 2
Click Here for Important Instructions	Cubicatto			Caman if	Cubinetta			Caman if	Tier 1	Her 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only	y after deductible?
Medical	□ All	□ All	unterent	зерагате	□ All	□ All	unierent	зерагате	□ All	☐ All
Emergency Room Services	<u> </u>			\$500.00					✓	
All Inpatient Hospital Services (inc. MH/SUD)	✓			\$500.00					✓	
***************************************		-								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00		П				
Services	L				_	_			_	_
Imaging (CT/PET Scans, MRIs)	V	<u> </u>	56%	\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V			J 0.00						
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	✓			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	v								
Outpatient racinty ree (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			☐ All	□ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs Non-Preferred Brand Drugs	▽			\$40.00 \$75.00					V	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00					<u> </u>	Ä
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments	? 🗆		Name:	BQ-BC POST						
Specialty Rx Coinsurance Maximum	:		Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay			Issuer HIOS ID:	41842						
# Days (1-10)										
Begin Primary Care Cost-Sharing After a Set Number of Visits	_									
# Visits (1-10) Begin Primary Care Deductible/Coinsurance After a Set Number o										
Copays										
# Copays (1-10)										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	78.70%									
Metal Tier:	Gold									
	NOTE: Office-visit-	specific cost-shar	ing is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator	0.0409 Seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	Gold ▼									
Desired Metal Tier		Dian Danafit Da	alaa	П	Tion	2 Dlan Danafit I	Design			
	Medical	Plan Benefit De	Combined	-	Medical	2 Plan Benefit I Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00	Combined	•	ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000			1		1				
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductib
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	All		4	☐ All	All			□ All	All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	<u>N</u>	Ц		\$500.00	Ш				V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						П
Services					_					
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00	_				V	_
Non-Preferred Brand Drugs	V			\$75.00					✓	
Specialty Drugs (i.e. high-cost)	V			\$120.00					~	
Options for Additional Benefit Design Limits:	_		Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010084	4-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Successf	iul.								
Actuarial Value:	79.56%									
Metal Tier:	Gold									
		services are not	subject to the dedi	uctible and have no	copay. Any ser	rvice with this co	st-sharing structure	is covered at	100% by the plan in t	he deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	e settings.					
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 iiii dai contii	Dation 7 and dist.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		er 1 Plan Benefit De	1			2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,0	00.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		T:	er 1				ier 2		Tion 1	Tier 2
<u>Click Here for Important Instructions</u>	Cubbanka			C 16	Cubbanks			C 'f	Tier 1	Her 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	☐ All	☐ All
				ĆE00.00						
Emergency Room Services	✓✓			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)		<u>v</u>								<u> </u>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
	V			450.00					V	
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services	V	V	56%	\$300.00						
Imaging (CT/PET Scans, MRIs) Speech Therapy			30%	\$30.00						
Speech Therapy				\$30.00						
Constituted and Physical Thorony				\$30.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization				\$0.00		П				
Laboratory Outpatient and Professional Services	<u> </u>	✓		\$0.00						
X-rays and Diagnostic Imaging	V	<u>v</u>								
Skilled Nursing Facility	V			\$500.00					<u> </u>	H
Skilled Nursing Facility				\$500.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•	31%	\$300.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					₹	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П	7	Name:	BQ-BC_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		=								
Calculate										
Status/Error Messages:	Error: Result is ou	itside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	75.99%									
Metal Tier:										
	NOTE: Office-visit	t-specific cost-shar	ing is applying to x-	rays in office setti	ngs. NOTE: Servi	ice-specific cost	-sharing is applying	for service(s) v	vith fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs	for those service(s).							
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	-									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)				-						
			•			•				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	☐ All			☐ All	All			□ All	All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
	L				_					
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy	_	_				_			_	_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	~	~								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	31%	\$300.00						
			5270	4500.00		_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	~			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	77.30%									
Metal Tier:	Gold									
			-				-		100% by the plan in t	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-specif	ic cost-sharing is a	applying for ser	vice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	i	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?			loyer Contribution		Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				1						
		1 Plan Benefit De		_		2 Plan Benefit D				
Deductible (\$)	Medical \$2,000.00	Drug \$250.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)				•		L				
MOOP if Separate (\$)		10.00		-						
						-				
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies only	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					_
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	56%	\$300.00						
Speech Therapy			3070	\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					✓	
Non-Preferred Brand Drugs	V			\$75.00					>	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description	1						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	78.90%									
Metal Tier:	Gold									
	NOTE: Office-visit-	specific cost-shari	ing is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_				2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	scian		Tion	· 2 Plan Benefit D	ocian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000			T		1				
MOOP if Separate (\$)				-						
							-			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services			5.50/	4000.00						
Imaging (CT/PET Scans, MRIs)			56%	\$300.00	•					
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services			100%	30.00						
X-rays and Diagnostic Imaging		₹	10070			H				
Skilled Nursing Facility	· ·			\$500.00					<u> </u>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BC_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
	79.76%									
	Gold									
	NOTE: One or more	services are not	subject to the dedu	uctible and have no	copay. Any sei	rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:			ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Dlan Danafit Da	alau	_	Tion	2 Plan Benefit I	Dasies			
	Medical	1 Plan Benefit De Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	1	100.00%								
MOOP (\$)						1				
MOOP if Separate (\$)				_						
,			-			•	•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	v after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)						Ō				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
					_	_				
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services Imaging (CT/PET Scans, MRIs)										
Speech Therapy				\$15.00						
Specificacy										_
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient racinty ree (e.g., Ambulatory Surgery Center)					_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00		_				
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)		Ш	Dian Description	\$100.00		Ш				
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?			Plan Description Name:	BQ-BD						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0 01					
# Days (1-10):				120 12						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	:									
Begin Primary Care Deductible/Coinsurance After a Set Number of	. 🗆									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	itul.								
Actuarial Value:	90.76%									
Metal Tier:	Platinum NOTE: Service-spec	ific cost-sharing is	anniving for cond	ica(s) with fac/prof	components of	verriding outpati	ent inputs for those	service(s)		
Additional Notes:	NOTE. Service-spec	and cost-stiding is	applying for servi	ice(s) with rat/prot	components, 0\	remunik outhati	ent inputs for triose	: sei vice(S).		
Additional Notes:										
Coloriation Times	0.042									
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier	□ Platinum ▼									
Desired Metal Her		r 1 Plan Benefit De	cian	П	Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined	†	Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00		Ī						
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$5,0	00.00								
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	r 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	y after deductible?
Medical	☐ All	☐ All			All	☐ All			□ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
					_					_
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services Imaging (CT/PET Scans, MRIs)						_				
Speech Therapy				\$15.00						
Specer merapy										
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	✓	V								
Drugs	□ All	□ All			— All				□ All	— □ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		7	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BD						
Specialty Rx Coinsurance Maximum:	_	1	Plan HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	П		Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):]								
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	riation.						
Actuarial Value: Metal Tier:	93.07%									
IVICLAL LICL.	NOTE: Service-sno	ecific cost-sharing is	anniving for service	re(s) with fac/prof	components ov	erriding outpatie	ent innuts for those	service(s)		
Additional Notes:	TVO TE. SETVICE-SPE	.cmc cost-snaring is	applying for serving	cc(s, with rac, prof	components, ov	critaing outpatit	and imputs for those	SCI VICE(S).		
Additional Notes.										
Calculation Time:	0.043 seconds									
	/5 5000									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			red Network O				
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum ▼	er 1 Plan Benefit De	alau.	T	Tian	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		ivicuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		•						
MOOP if Separate (\$)	1 - 7 -			-						
		•				•	-			
Click Here for Important Instructions		Tie	r 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
· ·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
				ć20.00						
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient	Ш	Ш		\$30.00					Ш	
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		~								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00		П				
				7	_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All		Ć4E 00	☐ All	☐ All			□ All	☐ All
Generics Preferred Brand Drugs				\$15.00 \$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00	1 7					
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-BD_POST_						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Error: Posult is ou	tside of [-4, +2] per	cent de minimis va	riation						
	85.50%		cent de minimi Va	mation.						
Metal Tier:	33.3070									
	NOTE: Service-sp	ecific cost-sharing is	applying for servi	ce(s) with fac/prof	components, ov	erriding outpati	ent inputs for those	service(s).		
Additional Notes:		0				5 1				
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Dlaw Bawafit Da	alau	_	Tion	2 Plan Benefit I	Dasies			
	Medical	1 Plan Benefit De Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)				T		1				
MOOP if Separate (\$)				-						
			-				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	v after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)						Ō				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00		П				
				400.00		П				
Specialist Visit		Ш		\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						_
Special merapy										_
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		✓	100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00						
				\$130.00	_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00		_				
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)		Ш	Dian Description	\$100.00		Ш				
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?			Plan Description Name:	BQ-BD_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0 01					
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?	'									
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	itul.								
Actuarial Value:	87.19%									
Metal Tier:	Platinum	ific cost sharing i	annhing for sand	ico(s) with fac/f	components s:	orriding outset:	ant innute for these	contico(s)		
Additional Notes	NOTE: Service-spec	inc cost-snaring is	applying for servi	ice(s) with tac/prof	components, ov	rei riuirig outpati	ent inputs for those	: service(s).		
Additional Notes:										
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Dlaw Bawafit Da	alau	_	Tion	2 Plan Benefit I	Dasies			
	Medical	1 Plan Benefit De Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)						1				
MOOP if Separate (\$)				_						
			-				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)						Ī				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
					_	_				
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Specificacy										-
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient racinty ree (e.g., Ambulatory Surgery Center)					_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)		Ш	Dian Description	\$100.00						Ш
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?			Plan Description Name:	BQ-BD_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0 01					
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Colombatic S	£1								
Status/Error Messages:	Calculation Success	itul.								
Actuarial Value: Metal Tier:	90.25% Platinum									
ivietai riei.	NOTE: Service-spec	ific cost-sharing is	anniving for send	ice(s) with fac/prof	components of	erriding outpoti	ent innuts for these	service(s)		
Additional Notes:	NOTE. Service-spec	and cost-stiating is	apprying for servi	icc(s) with rat/prof	components, 0	cornaing outpatt	enempues for those	. JCI VICE(3).		
Additional Notes:										
Coloriation Times	0.0204									
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	□ Platinum ▼									
Desired Metal Tier		r 1 Plan Benefit De	alau	П	Ties	2 Plan Benefit [) a siane			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		Ī						
MOOP if Separate (\$)				-						
			-				•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
						_				
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient	Ш	Ш		\$30.00						
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		✓								
					_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All		Ć45.00	□ All	☐ All			□ All	□ All
Generics				\$15.00 \$25.00						
Preferred Brand Drugs Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00	 					
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BD_POST_						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):		_								
Output Calculate										
	Error: Posult is ou	tside of [-4, +2] per	cent de minimis va	riation						
	92.50%	1310c 01 [-4, +2] per	cent de minimis Va	nation.						
Metal Tier:	32.3070									
	NOTE: Service-spe	ecific cost-sharing is	applying for servi	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:			5	., .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	0				
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	sian	П	Tion	· 2 Plan Benefit D	Nocian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,15					1				
MOOP if Separate (\$)				-						
			_			•	<u>-</u> '			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			☐ All	All			☐ All	☐ All
Emergency Room Services	<u> </u>	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Constallation (Constallation)				ć400.00		П				
Specialist Visit Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00	_	Ш				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	~								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V	33%	\$212.42						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	\[\sigma\]			\$40.00		_			<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost) Options for Additional Benefit Design Limits:	y		Plan Description	\$120.00		Ш			✓	
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010080	0-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	0 01					
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Calculation Sur-									
	Calculation Success 70.88%	siui.								
	70.88% Silver									
metal ner.		specific cost-shari	ng is applying to v-	rays in office settin	ngs. NOTF: Serv	ice-specific cost-	sharing is anniving	for service(s)	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	•		.a,s in office settin	.55. 14012. 3614	.cc specific cost-	STOTALE IS OPPOSITING		uc, pror compo	.ccs, overriding
Additional Motes.		(5)								
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	• • •	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	y after deductible?
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	□ All	□ All
Emergency Room Services	∨ ∨	V								
All Inpatient Hospital Services (inc. MH/SUD)	Y	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient	_			¢400.00						
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy				\$50.00						
				4=0.00						_
Occupational and Physical Therapy		Ш		\$50.00		Ш				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		✓	100%							
X-rays and Diagnostic Imaging		<u> </u>								
Skilled Nursing Facility	✓	✓								
										_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V	33%	\$212.42		-				_
Outpatient Surgery Physician/Surgical Services	V	V			_					
Drugs	□ All	□ All			☐ All	□ AII			☐ All	All
Generics				\$10.00						
Preferred Brand Drugs	_			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:	_	1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BQ-BE						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?	Ш		Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays?										
# Copays (1-10):]								
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	72.44%									
Metal Tier:										
			•				•		100% by the plan in	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-spec	ific cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(s).							
Calculation Time:	0.043 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			1	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	• • •	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V	<u> </u>								<u>_</u>
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy				\$50.00						
				······································						_
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	<u> </u>	☑								
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	✓	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	<u> </u>								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					✓	
Specialty Drugs (i.e. high-cost)	~			\$120.00					V	
Options for Additional Benefit Design Limits:		,	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	72.61%									
Metal Tier:										
			•				•		100% by the plan in	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-spec	ific cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(s).							
Calculation Time:	0.043 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			1	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	• • •	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	y after deductible?
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy				\$50.00						
				······································						_
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		☑	100%							
X-rays and Diagnostic Imaging	✓	✓	10070							
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	<u> </u>								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					_	
Non-Preferred Brand Drugs	V			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	~			\$120.00					V	
Options for Additional Benefit Design Limits:		,	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	73.72%									
Metal Tier:										
			•				•		100% by the plan in	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-spec	ific cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(s).							
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	3	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼	. 1 Dlan Danafit Da	alau	1	Ties	2 Dlaw Dawafit I	Design			
	Medical	1 Plan Benefit De Drug	Combined	+	Medical	2 Plan Benefit I Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00	Combined	•	ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)		50.00				1				
MOOP if Separate (\$)	7-0/			-						
			_				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	All			☐ All	All			☐ All	All
Emergency Room Services	V	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	56%	\$299.99						
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy				\$50.00	_					
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	Ŋ	✓								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•								
	✓	✓				П				
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ All	□ All			□ All	□ All
Drugs Generics				\$10.00						
Preferred Brand Drugs				\$40.00					V	Ä
Non-Preferred Brand Drugs	V			\$75.00		ä			✓	Ä
Specialty Drugs (i.e. high-cost)] [>			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays? # Copays (1-10):										
Output										
Calculate										
	Calculation Succes	sful.								
	71.78%									
Metal Tier:	Silver									
	NOTE: Office-visit-	specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	l Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		er 1 Plan Benefit De	1			2 Plan Benefit I				
5 1 111 (4)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%		-						
MOOP (\$)		150.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tie	er 1			т	ier 2		Tier 1	Tier 2
CHICK HERE FOR IMPORTANT INSTRUCTIONS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	□ All	uniciciit	Separate	□ All	All	uniciciit	зеринис	☐ All	☐ All
Emergency Room Services	Z	Z								
All Inpatient Hospital Services (inc. MH/SUD)	2	☑								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	56%	\$299.99						
Speech Therapy				\$50.00						
				¢50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	v	✓								
Drugs	☐ All	☐ All			☐ All	_ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓		Dian Daraniation	\$120.00	Ш				•	
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		7	Plan Description							
Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-BE 41842DC001008	0.01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842	10-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		=								
Calculate										
Status/Error Messages:		ıtside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	73.22%									
Metal Tier:										
			-			vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Of	fice-visit-specific co	st-sharing is apply	ing to x-rays in offi	ce settings.					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		7 iiii dai comai	out.on/unount.		2nd	l Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼				_					
		1 Plan Benefit De				2 Plan Benefit I				
Deductible (\$)	Medical \$2,750.00	Drug \$250.00	Combined	-	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,15			•		1				
MOOP if Separate (\$)	70,1 3	0.00		_						
Moor is separate (\$)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	, arter deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
					_					
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services		✓	56%	\$299.99						
Imaging (CT/PET Scans, MRIs) Speech Therapy			30%	\$50.00						
эреест тиегару										
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization	П	П		\$0.00						
Laboratory Outpatient and Professional Services	J N	v		J 0.00						
X-rays and Diagnostic Imaging		<u> </u>								
Skilled Nursing Facility	•	✓								
	V	V								П
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					_	_				_
Outpatient Surgery Physician/Surgical Services	N	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	> [\$75.00					V	
Specialty Drugs (i.e. high-cost)	>		Dian Description	\$120.00					V	
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		ĺ	Plan Description Name:	BQ-BE						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	0 01					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status/Error Messages:	Calculation Succes	cful								
	71.78%	siui.								
	71.78% Silver									
	NOTE: Office-visit-	specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:	3.2.2.110c visit	.,	2 J 8 t. 2 x	,	J					
, additional moces.										
Calculation Time:	0.043 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	n? □	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?	· 🗆	Annual Contri	bution Amount:		1s	t Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?	· 🗆	Annual Contin	bation Amount.		2nd	d Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			т	ier 2		Tier 1	Tier 2
CHERTICIE TOT IMPORTANT INSTRUCTIONS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		-
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?		separate	Copay applies only	after deductible?
Medical	□ All	□ All	uniciciit	эсрагисс	□ All	All	directore	зеринис	☐ All	☐ All
Emergency Room Services	▽	<u> </u>							0	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy			30/6	\$50.00						
эрееси тистару										
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		✓	100%	30.00						
X-rays and Diagnostic Imaging	v	₹	100/0							
Skilled Nursing Facility	₹	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:		7	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):		_								
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):		_								
Calculate										
Status/Error Messages:	Error: Posult is ou	tside of [-4, +2] per	reent de minimis v	ariation						
Actuarial Value:	73.22%	LSIUC 01 [-4, +2] per	cent de minimilis V	anautin.						
Metal Tier:	, 3.22/0									
metal nen	NOTE: One or mo	re services are not	subject to the ded	luctible and have no	CODAY Any ser	vice with this co	ost-sharing structure	is covered at	100% by the plan in t	he deductible
Additional Notes:				ing to x-rays in offic		vice with this tt	oc manning structure	covereu di	20070 by the plantill t	acaactible
Additional Notes:	.agc. 14012.011	ice visit specific co	se sharing is apply		ce settings.					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	sian		Tion	2 Plan Benefit [Docian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00	combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,15					1				
MOOP if Separate (\$)				-						
			_				_			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	All
Emergency Room Services	V	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
				4400.00	_					
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
Specific Control of the Control of t					1					
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	v			\$300.00					✓	
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	70.21%									
Metal Tier:	Silver									
				rays in office setti	ngs. NOTE: Serv	ice-specific cost-	-sharing is applying	for service(s) v	vith fac/prof compon	ents, overriding
Additional Notes:	outpatient inputs f	or those service(s)	l.							
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,15	0.00								
MOOP if Separate (\$)										
									1	
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
BA - di l	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		☐ All
Medical	□ All	□ All							□ All	
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	✓								
Speech Therapy				\$50.00						
				4	_					_
Occupational and Physical Therapy		Ш		\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		v	100%							
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	V								
				4	_	_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V			\$300.00					V	
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Calaulatian Cu									
Status/Error Messages:	Calculation Success	itui.								
Actuarial Value:	71.71%									
Metal Tier:	Silver		and the same of the same				and the same of the same		4000/ 1	la a al a al cast to t
			-				-		100% by the plan in t	
Additional Notes:				ing to x-rays in offic	ce settings. NOT	L: Service-speci	TIC COST-Sharing is a	ipplying for sei	vice(s) with fac/prof	:omponents,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Ailitual Colletti	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De				2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	. ,	50.00								
MOOP if Separate (\$)										
					ı					
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				······································	1					
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						

Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	v	☑								
X-rays and Diagnostic Imaging		✓								
Skilled Nursing Facility	<u> </u>	✓			ŏ					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	v	₹.								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:	•		Plan Description	:	•					
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-BE_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	71.70%									
Metal Tier:	Silver									
		-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:			5 FF 7 6 - 5 A	,	<u> </u>					
Additional Notes.										
Colculation Times	0.0000									
Calculation Time:	0.0586 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	□ Silver ▼									
Desired Metal Tier		r 1 Plan Benefit De	cian		Tion	· 2 Plan Benefit D	Nosian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00	Combined		Wieulcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)		50.00		T		1				
MOOP if Separate (\$)				-						
		•	-			•	•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Tuno of Ponofit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00		П				
	_				_	_				
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
Jeech Herapy										
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization	П			\$0.00						
Laboratory Outpatient and Professional Services		✓	100%							
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	_			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	<u> </u>			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BE_POST_ 41842DC001008	0.04					
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay?			Plan HIOS ID: Issuer HIOS ID:	41842	0-01					
# Days (1-10):	Ш		issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		-								
Calculate										
		tside of [-4, +2] per	cent de minimis va	ariation.						
	73.09%									
Metal Tier:										
			-			rvice with this co	st-sharing structure	is covered at	100% by the plan in	he deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Option:	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
	Tie	r 1 Plan Benefit De			Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00							
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☑ All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services	v			\$250.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					~	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Filliary Care visit to freat arrinjury or filliess (exc. Freventive, and A-rays)	V			\$25.00	_	Ц			~	
Specialist Visit	>			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00	_	_				_
Services	V			\$50.00					✓	
Imaging (CT/PET Scans, MRIs)	V	✓								
Speech Therapy	V			\$25.00					V	
	V			ć2F 00					V	
Occupational and Physical Therapy	V	Ш		\$25.00					_	
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	Y			\$500.00					~	
	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Y	⊻								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	Y			\$10.00					✓	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description	•						
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-BF						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040040	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
		tside of [-4, +2] per	cent de minimis va	ariation.						
	73.10%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	•		HSA/HRA Option	s	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	hutian Amount:		1st	Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	7		-				
MOOP if Separate (\$)			, , , , , , , ,	→						
,			•				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	/ arter deductible
Medical	✓ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	✓			\$250.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					~	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services	✓			\$50.00					✓	
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	✓			\$25.00					<u> </u>	
эрест петару				323.00						
Conventional and Dhysical Thoras	✓			\$25.00					✓	
Occupational and Physical Therapy				ćo 00	_	_				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging				4500.00	_					_
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
					_	_				
Outpatient Surgery Physician/Surgical Services	v	v								
Drugs	✓ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	<u> </u>			\$10.00					<u> </u>	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					~	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BF						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040040	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	73.39%									
Metal Tier:										
	NOTE: Office-visit-	specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier	□ Silver ▼									
Desired Metal Her		1 Plan Benefit De	sign		Tier	· 2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00							
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	✓ All	☐ All		· ·	☐ All	☐ All			☐ All	☐ All
Emergency Room Services	N			\$250.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	•			\$25.00					✓	
					_					
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	>			\$50.00					V	
Services		_	64%	\$250.00						
Imaging (CT/PET Scans, MRIs) Speech Therapy	N N		64%	\$25.00					✓ ✓	
эреест тиегару										
Occupational and Physical Therapy	V			\$25.00					✓	
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	>	V								
X-rays and Diagnostic Imaging	N	✓								
Skilled Nursing Facility	•			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•	44%	\$250.00						
Outpatient Surgery Physician/Surgical Services	>	V								
Drugs	☑ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs) <u>(</u>			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	•		Dian Danielation	\$120.00		Ш			•	
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?			Plan Description Name:	BQ-BF_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	6-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	0 01					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Success	ful								
	69.92%	iui.								
	Silver									
		pecific cost-shari	ing is applying to x-	rays in office settir	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s) v	with fac/prof compo	nents, overriding
	outpatient inputs fo			,		.,	Orr-1"'6		, ,	,
		- (- ,								
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	~		HSA/HRA Option	s	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	hution Amount:		1st	Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)		-	\$6,700.00	7						
MOOP if Separate (\$)			4 0). 00.00	→			<u> </u>			
moor ii separate (y)							-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	_	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?		separate	Copay applies only	after deductible
Medical	✓ All	□ All	uniciciit	Separate	□ All	□ All	directore	Separate	☐ All	☐ All
Emergency Room Services	▼			\$250.00	_				<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	V								V	
All impatient nospital services (inc. Min/SOD)	•	Ш		\$500.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					✓	
					_					
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					V	
Services										
Imaging (CT/PET Scans, MRIs)	V	V	64%	\$250.00						
Speech Therapy	V			\$25.00					V	
	V			\$25.00					✓	
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	•								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	V			\$500.00					✓	
					_	_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			□ All	□ All			✓ All	□ All
Generics	✓			\$10.00					✓	
Preferred Brand Drugs	<u> </u>			\$40.00					V	
Non-Preferred Brand Drugs	☑			\$75.00					V	
Specialty Drugs (i.e. high-cost)	☑			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-BF_POST_						
Specialty Rx Coinsurance Payments: Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	C 01					
		-	Issuer HIOS ID:	41842	D-U1					
Set a Maximum Number of Days for Charging an IP Copay?			issuer mios ib:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?	Ш									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
	72.47%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	1	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				7						
		Plan Benefit De		-		2 Plan Benefit D				
5 1 vil (A)	Medical	Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share) MOOP (\$)			100.00%	+						
MOOP (\$) MOOP if Separate (\$)			\$6,700.00	1						
WOOT II Separate (5)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☑ All	☐ All			☐ All	☐ All			□ All	☐ All
Emergency Room Services	V			\$250.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
				ć2F.00	_	_				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	▼			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	V			\$50.00		П			✓	
Services					_					
Imaging (CT/PET Scans, MRIs)	V	V	64%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	V			\$25.00					✓	
Preventive Care/Screening/Immunization				\$0.00		П				
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	•	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V	44%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	V			\$10.00					✓	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BF_POST_						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC0040046	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10): Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successi	ul.								
	70.03%									
	Silver									
				rays in office settin	gs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s)	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	r those service(s)								
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	~		HSA/HRA Option	S	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Ailitual Colletti	button Amount.		2nd	Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
		r 1 Plan Benefit De	1			2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%	_						
MOOP (\$)		,	\$6,700.00							
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	or 1			т	ier 2		Tier 1	Tier 2
CHICK THE TOT IMPORTANT MISCHARCEONS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?		separate	Copay applies only	/ after deductible
Medical	✓ All	☐ All	unicient	зериние	All	All	uniciciii	separate	□ All	☐ All
Emergency Room Services	<u> </u>			\$250.00	_				<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	V	<u> </u>		Ç230.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	V			\$25.00					V	
Specialist Visit				\$50.00		П			✓	
Mental/Behavioral Health and Substance Use Disorder Outpatient										_
Services	✓			\$50.00					✓	
Imaging (CT/PET Scans, MRIs)	V	✓	64%	\$250.00						
Speech Therapy	v			\$25.00					V	
Occupational and Physical Therapy	V			\$25.00					✓	
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	v	☑		T T T T T T T T T T T T T T T T T T T						
X-rays and Diagnostic Imaging	<u> </u>	✓								
Skilled Nursing Facility	✓			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V			П					
	<u> </u>	☑			_					
Outpatient Surgery Physician/Surgical Services										
Drugs	✓ All	□ All		4	☐ All	☐ All			✓ All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	V			\$40.00						
Non-Preferred Brand Drugs	> >			\$75.00					✓	
Specialty Drugs (i.e. high-cost)			Dian Danishina	\$120.00		Ш				
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		1	Plan Description Name:							
Specialty Rx Coinsurance Payments: Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	BQ-BF_POST_ 41842DC0040040	c 01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	-								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
	72.71%									
Metal Tier:		_								
	NOTE: Office-visit	-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
	Tie	r 1 Plan Benefit De			Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%	_						
MOOP (\$)			\$6,700.00							
MOOP if Separate (\$)							<u> </u>			
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	v after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☑ All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services	v			\$250.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					~	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Primary Care visit to Treat an injury or liness (exc. Preventive, and x-rays)	V			\$25.00	_	Ц			~	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	0			\$50.00	_	_				_
Services	V			\$50.00					✓	
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	V			\$25.00					V	
	V			ć2F 00					V	
Occupational and Physical Therapy	V	Ш		\$25.00					_	
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	Y			\$500.00					~	
	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	⊻								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	Y			\$10.00					✓	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	Y			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BG						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010043	3-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
		tside of [-4, +2] per	cent de minimis va	ariation.						
	73.10%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Option	S	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Ailitual Colletti	button Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
		r 1 Plan Benefit De	1			2 Plan Benefit				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%	_						
MOOP (\$)		,	\$6,700.00							
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	or 1			Т	ier 2		Tier 1	Tier 2
Circk Here for important instructions	Subject to	Subject to	Coinsurance, if	Conov if	Subject to	Subject to	Coinsurance, if	Conou if		
Type of Benefit	Deductible?	Coinsurance?	different	Copay, if separate	Deductible?	Coinsurance?		Copay, if separate	Copay applies only	y after deductible
Medical	✓ All	□ All	uniterent	зерагате	□ All	□ All	unierent	separate	☐ All	☐ All
Emergency Room Services	▽			\$250.00					<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$230.00		ä				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
	V								V	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					V	
Services				T						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	V			\$25.00					V	
Occupational and Dharical Theorem	V			\$25.00					✓	
Occupational and Physical Therapy Preventive Care/Screening/Immunization				¢0.00		_				
		□		\$0.00						
Laboratory Outpatient and Professional Services X-rays and Diagnostic Imaging	V	V								= =
	V			¢500.00	H				<u> </u>	
Skilled Nursing Facility				\$500.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	✓ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	•			\$10.00					V	
Preferred Brand Drugs	V			\$40.00					✓	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?]	Name:	BQ-BG						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010043	3-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status/Error Messages:	Error: Bosult is and	rido of [4 + 2] man	cont do minimis :	riation						
	Error: Result is out	.siue 01 [-4, +2] per	cent de minimis va	וומנוטוו.						
	73.39%									
Metal Tier:	NOTE: Office ::init	enocific cost shari	na is annivina to ::	rave in office catting	age.					
	NOTE: UTTICE-VISIT	-specific cost-snari	ing is applying to x-	rays in office settir	ıgs.					
Additional Notes:										
Calculation Time:	0.0586 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	batton Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				=						
		Plan Benefit De				2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%	+						
MOOP (\$)			\$6,700.00			T				
MOOP if Separate (\$)							I			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	✓ All	☐ All			☐ All	All			□ All	☐ All
Emergency Room Services	V			\$250.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	2			\$500.00					✓	
	_	_		4	_	_				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00	_	_				
Services	V			\$50.00					V	
Imaging (CT/PET Scans, MRIs)	V	✓	64%	\$250.00						
Speech Therapy	V			\$25.00					V	
	✓			\$25.00					✓	
Occupational and Physical Therapy		_			_	_				
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V			\$500.00					✓	
Skilled Nursing Facility				\$500.00		<u> </u>				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	44%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			☐ All	☐ All			☑ All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	>			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BG_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010043	3-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Successi	ul.								
	69.92%									
Metal Tier:	Silver									
	NOTE: Office-visit-s	pecific cost-shari	ing is applying to x-	rays in office settin	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s)	with fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	r those service(s)).							
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiered	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	hution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00							
MOOP if Separate (\$)										
Cital Harrison for Investment Institution		Tie	4				ier 2		Tier 1	Tier 2
Click Here for Important Instructions								- "	Her 1	Her 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies onl	y after deductible
Medical	✓ All	□ All	uniterent	зерагате	□ All	□ All	uniterent	separate	☐ All	☐ All
Emergency Room Services	V			\$250.00					▽	
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>			\$500.00	Ī	ā			✓	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
	V				_				V	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					✓	
Services			540/	4050.00						
Imaging (CT/PET Scans, MRIs)	V	<u> </u>	64%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	₹.			\$25.00					✓	
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	v	v								
X-rays and Diagnostic Imaging	☑	✓								
Skilled Nursing Facility	✓			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
					_	_				
Outpatient Surgery Physician/Surgical Services	V	v								
Drugs	✓ All	□ All		<u> </u>	☐ All	All			✓ All	□ All
Generics	V			\$10.00					v –	
Preferred Brand Drugs	V			\$40.00	_				2	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00		Ш			✓	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BG_POST_	2.04					
Specialty Rx Coinsurance Maximum:		-	Plan HIOS ID:	41842DC0010043	3-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		-								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?	_									
# Copays (1-10):										
Output		1								
Calculate										
Status/Error Messages:	Error: Result is out	side of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	72.47%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ing is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00	1						
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	1						
MOOP if Separate (\$)				→			<u> </u>			
			_				-			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Tune of Densit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Consu annlies only	, after deductible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	✓ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	Y			\$250.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	>	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	•			\$25.00					✓	
Specialist Visit	V			\$50.00					☑	
Mental/Behavioral Health and Substance Use Disorder Outpatient				·····						
Services	>			\$50.00					✓	
Imaging (CT/PET Scans, MRIs)	V	✓	64%	\$250.00		П				
Speech Therapy				\$25.00					V	
		·····								·····
Occupational and Physical Therapy	V			\$25.00					✓	
Preventive Care/Screening/Immunization	П	П		\$0.00						
Laboratory Outpatient and Professional Services		☑								
X-rays and Diagnostic Imaging		✓								
Skilled Nursing Facility	V			\$500.00					✓	
		·····								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V	44%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			□ All	☐ All			✓ All	☐ All
Generics	V			\$10.00					✓	П
Preferred Brand Drugs				\$40.00					✓	_
Non-Preferred Brand Drugs	N			\$75.00					✓	
Specialty Drugs (i.e. high-cost)) 🔽			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BQ-BG_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	3-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
	70.03%									
	Silver									
		pecific cost-shari	ng is applying to x-	rays in office settir	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s)	with fac/prof compo	nents, overriding
	outpatient inputs fo				-		5 7 6	(-)		. 0
nadicondi nocesi										
Calculation Time:	0.043 seconds									
Calculation Hills.	U.UHJ JECUTIUS									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Option	s	Tie	red Network Op	ition			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Cantril	husian Amarunt.		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,750.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	7		-				
MOOP if Separate (\$)			4 0). 00.00				<u> </u>			
							ı			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	, after deductible
Medical	✓ All	□ All	uniciciit	зериние	□ All	□ All	unicient	Separate	□ All	☐ All
Emergency Room Services	▼ All			\$250.00					▽	
	V			\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	M	<u>v</u>							Ц	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					✓	
Services										
Imaging (CT/PET Scans, MRIs)	V	V	64%	\$250.00						
Speech Therapy	V			\$25.00					V	
	V			\$25.00					✓	
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	V			\$500.00					✓	
					_					_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	✓ All	□ All			□ All	□ All			✓ All	□ All
Generics	<u> </u>			\$10.00					✓	
Preferred Brand Drugs	<u> </u>			\$40.00					V	
Non-Preferred Brand Drugs	<u> </u>			\$75.00					☑	
Specialty Drugs (i.e. high-cost)	✓			\$120.00		Ä			✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BQ-BG POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2 01					
Set a Maximum Number of Days for Charging an IP Copay?		-	Issuer HIOS ID:	41842	5-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		-								
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	72.71%									
Metal Tier:										
	NOTE: Office-visit	-specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	cian		Tion	· 2 Plan Benefit D	Nosian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00	Combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,15									
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	□ All	□ All
Emergency Room Services	Z All	<u> </u>							All	
All Inpatient Hospital Services (inc. MH/SUD)	V	v								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00		П				_
Services					_					
Imaging (CT/PET Scans, MRIs)		V	56%	\$299.99						
Speech Therapy				\$50.00						
Occupational and Dispiral Theorem				\$50.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		☑		30.00						
X-rays and Diagnostic Imaging		V								
Skilled Nursing Facility	·	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V	33%	\$212.42						
	_ _			Ŧ						
Outpatient Surgery Physician/Surgical Services		✓ □ All			□ All	□ All			□ □ All	□ All
Drugs Generics	□ All			\$10.00					□ All	
Preferred Brand Drugs				\$40.00					V	
Non-Preferred Brand Drugs				\$75.00					✓	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00						
Options for Additional Benefit Design Limits:			Plan Description:		•					
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Success	ful.								
	70.88%									
	Silver	nosific cost shari	na is applying to ::	rave in office catting	age NOTE: Cam-	ica spasific sast	charing is anni-i	for conjects	with fac/prof compo	nonte ovorridina
	outpatient inputs fo			rays in office settir	igo. INUTE: SEIV	ice-specific cost-	sitatitig is applyIng	ioi service(S)	with rat/prof compo	ierits, overriuing
Additional Notes:	outpatient inputs it	i iliose service(s)								
Calculation Time:	0.0352 seconds									
	3552 50001103									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆	Tiere	d Network Plan?	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	dition Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	r 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	v	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				7100.00						
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy			3070	\$50.00						
Specifically				750.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		- ✓	100%	30.00						
X-rays and Diagnostic Imaging		V	10070							
Skilled Nursing Facility	·	✓								
Skilled (Vd) Sing 1 activity										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V	33%	\$212.42						
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	>			\$120.00					✓	
Options for Additional Benefit Design Limits:		_	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	72.44%									
Metal Tier:					_					
			•				•		100% by the plan in t	
Additional Notes:				ing to x-rays in offic	ce settings. NOT	E: Service-speci	tic cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	• • •	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy				\$50.00						
				······································						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	<u> </u>	☑								
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	✓	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	<u> </u>								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					✓	
Specialty Drugs (i.e. high-cost)	~			\$120.00					V	
Options for Additional Benefit Design Limits:		,	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	72.61%									
Metal Tier:										
			•				•		100% by the plan in	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-spec	ific cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(s).							
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	? 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			1	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	• • •	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	56%	\$299.99						
Speech Therapy				\$50.00						
				······································						-
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		☑	100%							
X-rays and Diagnostic Imaging	v	✓	10070							
Skilled Nursing Facility	✓	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	<u> </u>								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					✓	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:		,	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays?										
# Copays (1-10):										
Output										
Calculate	E D- 1:1	and after 21								
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	73.72%									
Metal Tier:									4000/1 11 1 1	
			•				•		100% by the plan in	
Additional Notes:				ing to x-rays in offi	ce settings. NOT	E: Service-spec	tic cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(s).							
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Aimai contin	button Amount.		2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		1 Plan Benefit De	1	-		2 Plan Benefit				
Deductible (\$)	Medical \$2,750.00	Drug \$250.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,15			-						
MOOP if Separate (\$)	76,13	0.00		-						
Moor in Separate (3)							•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	✓			_					
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Filliary Care visit to Treat art flightly of filliess (exc. Preventive, and A-rays)				\$30.00	_					
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services	L				_					
Imaging (CT/PET Scans, MRIs)		V	56%	\$299.99						
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy		_		A	_	_				
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	▽	V								
X-rays and Diagnostic Imaging Skilled Nursing Facility	V	<u>v</u>								H
Skilled IVdIshig Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	All	□ All			— □ All				□ All	
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	71.78%									
Metal Tier:	Silver									
	NOTE: Office-visit-	specific cost-shari	ng is applying to x-	rays in office settir	ngs.					
Additional Notes:										
Calculation Time:	0.0469 seconds									
Final 2020 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De	1	_		2 Plan Benefit I				
5 L 11 L (A)	Medical	Drug	Combined	_	Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%		-						
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
CHECK TETE TOT IMPORTANCE MISTERCHOTS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	, after deductible
Medical	□ All	□ All	uniciciit	эсрагасс	□ All	□ All	uniciciit	Separate	□ All	□ All
Emergency Room Services	Z	<u> </u>							0	
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓				Ī				Ī
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	56%	\$299.99						
Speech Therapy				\$50.00						
				ć=0.00						_
Occupational and Physical Therapy				\$50.00		Ш				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	~	~								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All		*	All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V V			\$40.00					V	
Non-Preferred Brand Drugs	<u>v</u>			\$75.00					>	
Specialty Drugs (i.e. high-cost) Options for Additional Benefit Design Limits:	V		Plan Description	\$120.00					•	
Set a Maximum on Specialty Rx Coinsurance Payments?		٦	Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1_01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	101					
# Days (1-10):			1050001 11100 121	12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	73.22%									
Metal Tier:										
			-			vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Ailliadi Collai	bation Amount.		2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				=						
		1 Plan Benefit De	1			2 Plan Benefit I				
- L .: L .	Medical	Drug	Combined	_	Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00% \$8,15	100.00%		-						
MOOP (\$)	\$8,13	50.00		-						
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tie	er 1			т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	All	All			□ All	□ All			□ All	☐ All
Emergency Room Services	V	<u> </u>				<u> </u>				
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
				4=0.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00	_	_				_
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	56%	\$299.99						
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy						_			_	_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services	N I	<u> </u>								
X-rays and Diagnostic Imaging	>	<u> </u>								
Skilled Nursing Facility	>	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	✓								
Output Supplied Constitution (Constitution (Constitution)	V	✓				П				
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ All	□ All			□ All	□ All
Drugs Generics				\$10.00					□ All	
Preferred Brand Drugs				\$40.00					v	Ö
Non-Preferred Brand Drugs] [>			\$75.00					✓	Ö
Specialty Drugs (i.e. high-cost)] [\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Succes	sful								
	71.78%	J. 41.								
	Silver									
	NOTE: Office-visit-	specific cost-shari	ing is applying to x-	rays in office settir	ngs.					
Additional Notes:			, 0		-					
Calculation Time:	0.0391 seconds									
Final 2020 AV Calculator	1.1131 0000.103									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De	1	_		2 Plan Benefit I				
5 L 11 L (A)	Medical	Drug	Combined	_	Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%		-						
MOOP (\$)	\$8,1	50.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
CHECK TETE TOT IMPORTANCE MISTERCHOTS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	, after deductible
Medical	□ All	□ All	uniciciit	эсрагасс	□ All	□ All	uniciciit	Separate	□ All	□ All
Emergency Room Services	Z	<u> </u>							0	
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓				Ī				Ī
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	56%	\$299.99						
Speech Therapy				\$50.00						
				ć=0.00						_
Occupational and Physical Therapy				\$50.00		Ш				_
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	~	~								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All		*	All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V V			\$40.00					V	
Non-Preferred Brand Drugs	<u>v</u>			\$75.00					>	
Specialty Drugs (i.e. high-cost) Options for Additional Benefit Design Limits:	V		Plan Description	\$120.00					•	
Set a Maximum on Specialty Rx Coinsurance Payments?		٦	Name:	BQ-BI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1_01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	101					
# Days (1-10):			1050001 11100 121	12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	rcent de minimis va	ariation.						
Actuarial Value:	73.22%									
Metal Tier:										
			-			vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_				2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Fiel		1 Plan Benefit De	sign	T	Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$8,15	0.00				•				
MOOP if Separate (\$)				-						
Click Hore for Important Instructions		Tie	1			T	er 2		Tier 1	Tier 2
<u>Click Here for Important Instructions</u>	Subject to	Subject to	Coinsurance, if	Caman if	Subject to	Subject to	Coinsurance, if	Canan if	Heri	Her Z
Type of Benefit	Deductible?	Coinsurance?	different	Copay, if separate	Deductible?	Coinsurance?	different	Copay, if separate	Copay applies only	after deductible
Medical	□ All	□ All	uniterent	зерагате	□ All	□ All	unierent	зерагате	☐ All	□ All
Emergency Room Services	V	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	▽								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy				\$0.00		_				
Preventive Care/Screening/Immunization Laboratory Outpatient and Professional Services	✓	<u> </u>		\$0.00						
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	☑	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<u> </u>			\$300.00					<u> </u>	
	V	V								
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ All	All			□ All	□ All
Drugs Generics				\$10.00						
Preferred Brand Drugs	v v			\$40.00					v v	
Non-Preferred Brand Drugs	✓			\$75.00					V	
Specialty Drugs (i.e. high-cost)	- ✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040101	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	70.21%									
Metal Tier:	Silver									
				rays in office settin	ngs. NOTE: Serv	ice-specific cost-	sharing is applying	for service(s) v	vith fac/prof compo	nents, overriding
Additional Notes:	outpatient inputs fo	or those service(s)								
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		A	hardina Amazanaka		15	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Silver ▼			_						
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,150	0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	or 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	y after deductible
Medical	□ All	□ All	unician	Separate	☐ All	All	uniciciii	эериние	□ All	☐ All
Emergency Room Services	<u> </u>	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	✓	v								

Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient	_			¢100.00	_	_				
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00					_	
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V			\$300.00					~	
Outpatient Surgery Physician/Surgical Services	☑	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					✓	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BI_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	71.71%									
Metal Tier:	Silver									
	NOTE: One or more	services are not	subject to the dedu	uctible and have no	copay. Any sei	rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office overriding outpaties			ng to x-rays in offic	ce settings. NO	ΓΕ: Service-speci	fic cost-sharing is a	pplying for ser	vice(s) with fac/pro	components,
Calculation Time:	0.0508 seconds									
Final 2020 AV Calculator	5.5500 30001103									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		7 ii ii idai Comen			2nd	l Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		r 1 Plan Benefit De				2 Plan Benefit I				
Deductible (\$)	Medical \$2,750.00	Drug \$250.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)		50.00		-						
MOOP if Separate (\$)		1		-						
Moor in Separate (5)										
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
- 4- 4-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1.411
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	✓	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
	L									
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services	v	<u> </u>								_
Imaging (CT/PET Scans, MRIs)				\$50.00					·	
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization	П	П		\$0.00						
Laboratory Outpatient and Professional Services				Q0.00						
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	✓	✓								
		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓				_	_				
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	~			\$120.00					✓	
Options for Additional Benefit Design Limits: Set a Maximum on Specialty Rx Coinsurance Payments?		1	Plan Description Name:	BQ-BI POST						
Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1_01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842	101					
# Days (1-10):				12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Succes	STUI.								
	71.70% Silver									
		-specific cost-shari	ng is anniving to v	rays in office settir	ngs					
Additional Notes:	NOTE. OTTICE-VISIL	specific cost-stidii	ing is applying to x-	rays in office setti	1163.					
Additional NOTES.										
Calculation Time:	0.043 seconds									
Final 2020 AV Calculator	0.0+3 3econus									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Fiel		r 1 Plan Benefit De	sign		Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,750.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$8,1	50.00				•				
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	☐ All	□ All
Emergency Room Services	□ All	✓ All			□ All					
All Inpatient Hospital Services (inc. MH/SUD)	V	<u> </u>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		4400.00	_				_	
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization			4000/	\$0.00						_
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging Skilled Nursing Facility	V	<u> </u>								
Skilled Nulsing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	~			\$120.00					~	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BQ-BI_POST_ 41842DC004010:	1 01					
Set a Maximum Number of Days for Charging an IP Copay?		-	Issuer HIOS ID:	41842	1-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	F D. 111	and after 21								
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value: Metal Tier:	73.09%									
rectal rich.	NOTE: One or mor	re services are not	subject to the ded	uctible and have no	copav. Anv ser	vice with this co-	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:			-	ing to x-rays in office						
, additional Hotes.	J2.2.3		3	J	0					
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s		ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		r 1 Plan Benefit De	cian		Tion	· 2 Plan Benefit [Docian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	combined		Wicaicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00				*				
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All		4250.00	All	All			□ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)		Ш								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient						······			***************************************	
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)										
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization				\$0.00						_
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						H
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BJ	0.04					
Specialty Rx Coinsurance Maximum:		+	Plan HIOS ID: Issuer HIOS ID:	41842DC001006 41842	8-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):]								
Output										
Calculate	Colonial C	£l								
Status/Error Messages:	Calculation Succes	sstul.								
Actuarial Value: Metal Tier:	90.76% Platinum									
metal ner.		ecific cost-sharing is	anniving for servi	ce(s) with fac/prof	components of	verriding outpatie	ent inputs for those	service(s)		
Additional Notes:	Jei vice-spe	.cc cost snaring is	SPRINING TOT SELVE	ccis, with rac, prof	coponenca, o	cung outpath	cput5 101 t11036	. 50, 100(5).		
Additional Notes.										
Calculation Time:	0.0352 seconds									
Carcaration rimer	0.0002 00001103									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dai contin	out.on/unounc.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻			_	_					
		r 1 Plan Benefit De	T -			2 Plan Benefit I				
Dealer Albert (A)	Medical	Drug \$0.00	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)	\$0.00 100.00%	100.00%								
MOOP (\$)		00.00								
MOOP (\$) MOOP if Separate (\$)	\$3,0	1		-						
Wool in Separate (5)			1				ı			
Click Here for Important Instructions		Tie	r 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	☐ All	☐ All			□All	☐ All			□ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
	_			44= 00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				¢20.00	_	_				_
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)										
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy]								1	-
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		<u> </u>	100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
O testina Common Discision (Coming Library)	V	V								
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ □ All				□ All	
Drugs Generics				\$15.00	All					All
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00	-					-
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-BJ						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status / France Massages	Faren De le !-	toldo of [4 : 2]	aank da miliitiisti	, minting						
		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value: Metal Tier:	93.07%									
	NOTE: Service-co	ecific cost-sharing is	anniving for send	ce(s) with fac/prof	components of	erriding outpatie	ent innuts for those	service(s)		
Additional Notes:	JEI VICE-Spi	conc cost-snaring is	applying for servi	ccio, with rac/prof	components, 00	c. name outpath	inputs for those	JC1 VICC(3).		
Additional Notes.										
Calculation Time:	0.0312 seconds									
Calculation Time:	u.u312 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution?	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	sian	П	Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)		\$0.00	Companies	i	medical	5.48	Compared			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$5,0	00.00				•				
MOOP if Separate (\$)										
			_			_				
<u>Click Here for Important Instructions</u>	Cublanta	Tie		C 16	Cubicate		er 2	C 'f	Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies onl	y after deductible?
Medical	□ All	□ All	unierent	зерагате	□ All	□ All	uniterent	зерагате	☐ All	□ All
Emergency Room Services	0			\$250.00		-			0	
All Inpatient Hospital Services (inc. MH/SUD)				Q230.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services										
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		V		·						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00						
				V130.00		_				
Outpatient Surgery Physician/Surgical Services	✓ □ All	□ All								□ All
Drugs Generics				\$15.00		All			□ All	□ All
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00	_					
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description:						•	
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BJ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of		-								
Copays?										
# Copays (1-10):										
Output		1								
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	riation.						
Actuarial Value:	85.50%									
Metal Tier:							_			
	NOTE: Service-spe	cific cost-sharing is	applying for service	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0273 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_	201 0 611				
		1 Plan Benefit De		-		2 Plan Benefit I				
Deductible (\$)	Medical \$0.00	Drug \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$5,00			-		1				
MOOP if Separate (\$)				-						
			_			•	•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Consu annlies on	ly after deductible?
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		y arter deductible:
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
					_					_
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						_
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services		V	100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00						
Outpatient Surgery Physician/Surgical Services	☑	V								
Drugs	All	□ All			_ All	All			All	— — — — — — — — — — — — — — — — — — —
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BQ-BJ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	87.19%									
Metal Tier:	Platinum									
	NOTE: Service-spec	ific cost-sharing i	s applying for servi	ice(s) with fac/prof	components, ov	erriding outpati	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0312 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	cian		Tion	2 Plan Benefit D	ocian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$5,0	00.00								
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All		4250.00	All	□ All			□ All	All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00	_	_				_
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization		П		\$0.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		✓								
	V	V								
Outpatient Surgery Physician/Surgical Services	□All	□ All			□ □ All				□ All	□ All
Drugs Generics				\$15.00	□ All				□ All	
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description:		•					
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BQ-BJ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010068	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays? # Copays (1-10):										
Output		J								
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	90.25%									
Metal Tier:	Platinum									
	NOTE: Service-spe	ecific cost-sharing is	applying for servi	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0312 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			red Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum ▼	u 1 Dian Danafit Da	alau.	_	Ties	2 Dlan Danafit F	Danism			
	Medical	er 1 Plan Benefit De Drug	Combined	-	Medical	2 Plan Benefit I Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-		!				
MOOP if Separate (\$)	+=/-			-						
		•					•			
Click Here for Important Instructions		Tie	r 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies only	arter deductible:
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										Ī
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
					_					-
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Special Therapy										
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization				\$0.00						
Laboratory Outpatient and Professional Services			100%							
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		✓								
					_	_				_
Outpatient Surgery Physician/Surgical Services	>	V								
Drugs	□ All	□ All		4	☐ All	☐ AII			□ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs Specialty Drugs (i.e. high-cost)				\$50.00 \$100.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П	7	Name:	BQ-BJ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Error: Decult is a:	tside of [-4 +2] ===	cent de minimis : :	ariation						
	92.50%	itside of [-4, +2] per	cent de minimis Va	ariaciOII.						
Metal Tier:	J2.JU/0									
	NOTE: Service-sn	ecific cost-sharing is	applying for servi	ice(s) with fac/prof	components. ov	erriding outpatio	ent inputs for those	service(s).		
Additional Notes:	2.2.22.7.00 sp					o o acpati				
, additional froces.										
Calculation Time:	0.0312 seconds									
EXIZER XXIII () () () () () () () () ()	seco.ius									



Efren Tanhehco Supervisory Actuary Department of Insurance, Securities and Banking 810 First Street, NE, Ste. 701 Washington, DC 20002

RE: Proprietary and Confidential Information UnitedHealthcare Risk Adjustment Data

HIOS Issuer IDs: 21066 UnitedHealthcare of the Mid-Atlantic, Inc.; 41842 UnitedHealthcare Insurance Company; 75753 Optimum Choice, Inc.

Dear Mr. Tanhehco:

The companies listed above (collectively referred to herein as "United" in either the singular or plural forms) are submitting data for the 2018 RATEE files at the request of the Department of Insurance, Securities and Banking. United submits in confidence this carrier-specific private data and this letter applies to any submission reasonably correlating to the 2018 RATEE files.

Under state law, this carrier-specific private information is non-financial, strictly confidential proprietary commercial information and not subject to disclosure under the D.C. Code § 2-534(a), CDCR 1-406.2, and is not a public record subject to disclosure requirements under D.C. Code § 2-534. It is non-public information submitted in confidence to the insurance commissioner that would give advantage to a competitor. Disclosure of this information would be detrimental to the best interests of the public because plan issuers compete on a product strategy that entices consumers to purchase its products and increase plan membership. Knowing a competitor's strategy beforehand confers a competitive advantage to issuers with sufficient resources to adjust to the competitor's strategy before going to market instead of waiting until the next adjustment window in a market. If a filing's confidential information such as risk scores prompts an issuer to see it is the only one offering a certain type of product (e.g. a wide network metal level (platinum) or cost sharing feature (0% member cost sharing for emergency room visits)), then issuers with sufficient resources to adjust have an unfair advance opportunity to remove those plans or adjust strategies. For example, if an issuer sees the competition has an emergency room copay of \$500 but they had \$250, it can likewise adjust to \$500 before going to market, which deprives consumers of the opportunity to take advantage of issuer competitive behavior.

We respectfully request the Department refrain from disclosing United's carrier-specific information to any other entity. Disclosure may cause substantial competitive harm by giving an unfair advantage to our competitors that is specific and reasonably foreseeable. Re-disclosure would enable competitors to model the above-named company's business portfolios pertaining to these submissions and unfairly adjust their strategy before going to market instead of waiting until the next opportunity to adjust in the relevant market. Accordingly, we respectfully request carrier-specific information not be redisclosed to any other person, including state or federal regulatory agencies, unless United consents in writing to the disclosure and the recipient agrees in writing prior to receipt to maintain the confidential proprietary and/or trade secret nature of the information.

Thank you in advance for your cooperation with this request. Sincerely,

Carol Tobiassen

and Polissen

Director, Health Care Reform Financial Oversight

UnitedHealthcare

SERFF Tracking #: UHLC-131909980 State Tracking #: Company Tracking #:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

	Schedule Item			Replacement	
Creation Date	Status	Schedule	Schedule Item Name	Creation Date	Attached Document(s)
04/19/2019		Rate	Rate Filing Exhibits	05/29/2019	DC-SG-UHIC-Exhibits 2020-1-v1.xlsx
04/19/2019		Supporting Document	Risk Adjustment RATEE Data	05/27/2019	41842.RATEE.D20180501T060434. P.xml (Superceded) DC Confidentiality Cover Letter EDGE Data 5.24.19.pdf

SERFF Tracking #: UHLC-131909980 State Tracking #: Company Tracking #:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2020-01

Project Name/Number:

Attachment 41842.RATEE.D20180501T060434.P.xml is not a PDF document and cannot be reproduced here.